MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Embassy Suites
1250 22nd Street, N.W.
Washington, D.C.
Monday, November 23, 1998

The meeting in the above-entitled matter convened, pursuant to notice at 9:44 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair

JOSEPH P. NEWHOUSE, Ph.D., Vice Chair

P. WILLIAM CURRERI, M.D.

ANNE JACKSON

SPENCER JOHNSON

PETER KEMPER, Ph.D.

JUDITH LAVE, Ph.D.

DONALD THEODORE LEWERS, M.D.

WILLIAM A. MacBAIN

WOODROW A. MYERS, M.D.

JANET G. NEWPORT

ALICE ROSENBLATT

JOHN W. ROWE, M.D.

GERALD M. SHEA

C O N T E N T S

P R O C E E D I N G S

DR. WILENSKY: The first session this morning is the final rule for the fee schedule. Kevin?

DR. HAYES: Thank you. Good morning. If you'll recall at last month's Commission meeting, we talked about a workplan for physician payment issues to be addressed in the Commission's March report. At the time, we knew that HCFA was about to release the Medicare fee schedule final rule for 1999. At the meeting, staff promised to review the rule and bring to you any additional issues that came up there that you might want to consider for the March report.

As it turns out, the rule came out I think it was the Monday after the last Commission meeting. As we reviewed the rule we came up with really two sets of issues that the Commission might want to consider. One has to do with some issues for the March report. The other has to do with refinement issues.

HCFA spends a fair amount of time in the review talking about refinement of the resource-based practice expense relative value units for the fee schedule. There are many, many issues that are deferred to that refinement process. HCFA is proceeding with plans to set up the refinement process and it would start next year. At this point, they are looking for good ideas about how to proceed with that refinement process. They've asked for comments on refinement and other issues, as well, but mainly on refinement, and asked that those comments be submitted by January 4th.

So one issue for the Commission this morning, to me, kind of a priority for this morning would be whether or not you want to submit comments on the refinement process and what the nature of those comments should be. If you do want to submit such a letter, we would have a draft of it for you at next month's meeting.

So what I thought I would do this morning is to just quickly go over some of the key points made in the final rule, talk for a bit about these refinement issues, and then there's a couple of things I can say about the sustainable growth rate system. Simultaneous with the release of the final rule, HCFA published the sustainable growth rate for fiscal year 1999. So there's a couple of issues related to the SGR system that are talked about in that notice. These are things that maybe we'd want to pick up for the March report.

So now, let me just say a couple of things about the rule. One of the things that's addressed in the document is the conversion factor, fee-schedules conversion factor update for 1999. That is a plus 2.3 percent. It's made up of a 2.3 percent increase in the Medicare economic index. This is an index which measures the prices of resources that physicians use to provide services. And no change in the other part of the update, which is the sustainable growth rate systems update adjustment factor. This is a part of the SGR system that compares actual and allowed spending.

Most of the rule, as I said, addresses the matter of resource-based practice expense RVUs. Probably the most important point to make about that is that HCFA's continuing to use their top-down methodology, the one that they introduced in a proposed rule which came out in June, one that you all reviewed and commented on.

So that what we see then is that while they've made some changes in the methodology, largely I would say of a technical nature, in general the practice expense RVUs and the final rule have a similar effect of payment rates as those that were in the proposed rule.

In a second I'll show you a table that was in a paper we sent out that summarizes those.

The other thing that's in the rule has to do with these refinement matters, and that we'll take up after we look first at this table. It just summarizes the changes in payment rates. These would be the changes that would occur over the four year transition to resource-based practice expense RVUs. If you recall,

those RVUs will be phased in from 1999 through the year 2002. So if you kind of scan over this table, you'll see that the effects on payment rates, the values in the proposed rule versus those in the final rule, are pretty similar.

So let's talk for a second about these refinement issues, our next slide here. I just would say that there's really two categories of refinement issues. The first has to do with service-specific data issues. This is, for the most part, the information that HCFA's used on a direct cost of providing specific services, the staff, the supplies, the equipment and so on, the costs associated with specific services. These are data that came from those CPEPs, the clinical practice expert panels that HCFA used to try to collect this kind of information.

I think one thing to say about these service-specific data issues, it looks like there is a process emerging that will address them. The AMA's relative value scale update committee, or RUC, has set up a practice expense advisory committee, or PEAC, which is going to tackle these issues.

I went to a RUC meeting on Saturday and they're pretty well on the way to setting up this PEAC. The committee's first meeting will occur in February. The RUC identified a range of issues for this group to deal with, and so on. So it seems like, in general, we're pretty much on a path toward resolving a lot of these service-specific issues. It's not to minimize the scope of the effort. There's a lot of work required here. But just from a process standpoint, it looks like there's a way to resolve some of these issues.

There is another set of refinement issues talked about in the rule, which are a bit of a different story, and that has to do with what HCFA calls technical and methodological issues. These issues cover a range of topics. They have to do with the matter of what some view as a bias in HCFA's top down methodology in favor of high revenue specialties. It has to do with how additional data will be collected on a physician's aggregate practice costs.

If you recall right now, HCFA's getting those data from a survey conducted by the AMA. The problem with the survey is that some specialties are under represented, and there are other technical issues surrounding the survey. But it's a matter of just augmenting the survey on a bit of methodological issue that's going to need to be addressed.

Another issue I would put in this category is one that this Commission addressed in its March 1998 report, and that has to do with a proposal that HCFA advanced early on to reduce practice expense payments for services provided in conjunction with an office visit service. If you recall, HCFA had originally proposed to make a 50 percent reduction in practice expense payments for these services.

So if we had a patient coming in for an office visit and getting an EKG, HCFA proposed to reduce the practice expense payment for the EKG by 50 percent on the assumption that there were some efficiencies associated with providing some services together. But anyway, HCFA has not given up on this idea even though, based in part on our comments, they decided to put it on hold for now.

There's just a whole list of these kinds of issues that are going to need to be addressed through some kind of a process that will start next year.

Just stepping back and just kind of thinking about broadly about how HCFA might go about dealing with these issues, I thought first about just the expertise that they'll need. Given what they're trying to deal with here, it would seem like some payment methods issues would be important. They'll need some expertise on survey research, accounting, and so on, in addition to just representation and participation from those in the physician community.

The other way to think about this process has to do with how they might organize it. HCFA has had some experience setting up fairly formal advisory committees, and they could do so again in this case.

Alternatively, they could work with some kind of a more independent entity, and I'm thinking here about the RUC that I mentioned earlier. That's the kind of organization that has advised HCFA on some of these matters.

And finally, as HCFA notes in the rule, they could rely on contractor support. In that way, using contractors, they would pass along these particular issues to contractors, get back reports, work with stakeholders, meet with them and so on, and ultimately formalize whatever decisions they make through the rulemaking process.

So these are just some of the considerations, I think, involved in the process and some of the things you might want to think about if we decide that we want to submit comments on refinement process.

Leaving that aside for a moment, let me just say a couple of things about the sustainable growth rate system and the notice that HCFA published on that. The sustainable growth rate for fiscal year 1999 will be a minus 0.3 percent. The primary reason why this rate is negative is that HCFA's anticipating a decrease in fee-for-service enrollment during fiscal year 1999, mainly because of shifts in beneficiaries toward Medicare+Choice plans.

In addition to publishing this rate, HCFA identifies a couple of issues which we might want to consider for the March report. One has to do with correction of estimates. As you recall, the sustainable growth rate is made up of four factors. One has to do with changes in fees. Another has to do, as I mentioned, with projections in fee-for-service enrollment. One is real GDP per capita. And finally, there is a factor for changes in expenditure for physician services due to changes in law and regulations.

Because all these four factors are projections, there's some possibility that they will be in error and later data might show that they're in error. And so the question now is should HCFA have the potential to go back and make corrections for those earlier estimates. They are kind of unclear on their authority in this case, and this might be something we can consider and make a recommendation on.

The other has to do with mismatches in time periods. There are a number of calculations necessary with the sustainable growth rate system and they're all based on data, as it turns out, for different time periods. As you can see, the sustainable growth rate is calculated on a fiscal year basis. It's used for a conversion factor update, which is on a calendar year basis. There's some other calculations in this process which are for a year ending on March 31st. Because of these mismatches in time periods, HCFA is concerned that this system will kind of start to oscillate, it will increase payment rates one year and decrease them to the other extreme the next, and so on, just because of this mismatches in time periods problem.

So this would be the kind of thing which we could explore further, give you some analysis on, and so on, for the March report if you think it's important to deal with it.

DR. WILENSKY: Could you just clarify, to the extent that you know this, the issue about whether they have the authority? I was also unclear about if there are errors in the estimates, for example the number of people who will leave traditional Medicare seems like a prime candidate for having an error in some direction.

Is there some question about whether or not they can go back after the fact and introduce correct information to recalculate the sustainable growth rate?

DR. HAYES: Yes, this is some question about whether they have the legislative authority to do that and I understand that HCFA's general counsel or legal counsel, whatever the term is, has been involved in this and they just haven't been able to resolve that issue yet.

DR. CURRERI: I do think that there was much more response to this final rule than there was even for the work values. I guess I've had at least 30 different organizations talk to me about it.

It's not what the final rule says, it's what it doesn't say, I think that's the real problem. The problem was that many organizations that thought they had really substantial issues, they really don't get

addressed at all in the response and there's a lot of disappointment in that among the physician community, I would say.

Even if you look at it from the standpoint of what this Commission reported in their letter, I don't think there was very much response to it. We pointed out that there was problems with CPEP. HCFA essentially, in the final rule, says yes, there are problems. But it's unclear to me what they're going to do about them.

We also pointed out the problem with the AMA/SMS survey with the under reporting in certain specialties. And they say yes, that does occur. But again it doesn't say very much what they're going to do about it.

But I think the thing that disturbs me most about it is they're delaying what they're going to do with regard to future revisions. It seems to me this is very important because it is potentially possible to have real access problems with regard to specific codes that simply won't be used because a perception of unfair payment. These are, by and large, problems that relate back to the CPEP process.

So I was hopeful at least that there would be a much more high end approach to how they were going to revise the codes as they found the mistakes. I personally think that this is important to get on with now because these are going to come up, and there will be I think access problems in small areas that we probably will never pick up because they'll be individual codes.

I personally think that the PEAC process might be the way to go, because it parallels the process that's in place for the work values and it would make the two situations similar. So I think that we should make a recommendation or we should comment on refinement. I've already expressed what I think is the best way to go with that.

I wanted to ask one question that doesn't relate to practice expenses but relates to malpractice expenses. It relates to when I reread your report from last month, and I want to make sure I have this right. When PPRC suggested the program, they suggested that there be differences based on specialty because there were different costs of insurance from specialty to specialty. But also, that there would be a factor in there for work values on the theory that work values had, in their construction, stress, risk, time, a variety of other things.

As I understood what you wrote, they have instructed Peat, Marwick to ignore the work values and simply do specialty differences. This makes no sense to me at all because even if one takes the same specialty, if the physician does a high risk area it seems to me he ought to be reimbursed more for taking the higher risk for that code. And when he does a procedure or an examination that has no risk, he probably shouldn't get paid very much for it because the likelihood of a suit is very small.

Can we comment on this? Or is there a way that we can express, if the rest of the Commission agrees with me, that this is probably not appropriate? A perfect example, for instance, for a neurosurgeon who does a spinal tap with very little risk or does a brain operation with very high risk. He's going to get the same amount of malpractice adjustment, it makes no sense.

DR. HAYES: Sure. If you recall from last month's meeting, this issue came up a bit and Joe had some very specific comments along that exact same line. My thought was that if we choose to submit a comment letter to HCFA what I was going to try to convince you to do was to also include in that letter some comments about the malpractice expense payments.

The statement of work that you talked about that's been given to Peat, Marwick does lay out a methodology. It is a matter of public record. And I think it would be something that we certainly have the ability to comment on.

The other point I would make, and I'm not trying to make excuses for HCFA, please don't get me wrong, but I think they believe that Peat, Marwick -- given the way they've structured the work -- that Peat, Marwick has the capability of coming back to them with an alternative methodology to the one they call a simple methodology that is based strictly on specialty.

But the problem is that you're kind of taking a chance then. We're in kind of a limbo state now, not knowing what Peat, Marwick is going to do. So it might be a good idea at this point, well before HCFA's at the point where they're trying to put together a proposed rule, to comment and say this is what we think.

So my plan was to give you a comment letter that would address both the refinement issues and the malpractice issues.

DR. LEWERS: Following up on that, maybe it's the same area that Bill's talking about, but haven't they pulled some of the potential percentage for liability over into practice expense now? I think that's a separate issue, isn't it? Or is it the same one you're talking about?

DR. CURRERI: No, it's a separate issue.

DR. LEWERS: Because how they can say that without any evaluation of the liability issue that it's going to be less percentage of the total payment is unclear to me at all. I think there's something in there about that. I wonder if you could check that.

DR. CURRERI: I think it went from 5 percent to 3 percent.

DR. LEWERS: 3.5 or something. I mean, that's just -- the liability rates are going up. There's no question about that. To say that it is a smaller percentage of the final product I think is ludicrous. So I think there definitely needs to be some statement along that line.

You might evaluate that and let us know exactly what that is, but I know there is a reduction.

There may be more on that, I don't know if anybody had any comment?

DR. HAYES: The issue here has to do with calibration of the components of the fee schedule. If you recall, we have three components of the fee schedule, work, practice expense and malpractice expense. The way the system is set up, each of those components is designed to mirror physicians use of their revenues, either for their income, for their practice expenses, or for their malpractice expenses.

As part of the final rule, HCFA updated those components with new information. What has happened is the malpractice expense component of the fee schedule has gone from roughly 5 percent down to 3 percent, based upon the latest available information on how physician's revenues are being used.

So it does, in a sense, look like malpractice expense is going to become less important, but based on what you're saying on increases in professional liability insurance premiums, there seems to be an inconsistency there and we can see if we can work that out and give you some more information.

DR. LEWERS: Humor to call it liability, not malpractice, if you don't mind. Most of it is not malpractice.

DR. HAYES: Right. I understand.

DR. LEWERS: They've also done some manipulation in utilization of the conversion factors in areas which is changing some of the emphasis on direct and indirect expenses in the practice expense. Do you have any information on that or can you help us with that? And should we comment on the utilization and manipulation in the conversion factor to achieve either budget neutrality or to achieve an ultimate end goal?

DR. HAYES: I think you've asked two questions. One has to do with how direct and indirect expenses are dealt with in practice expense, and that is one of the issues that's on the list for refinement. HCFA realizes that there's some limitations in their current methodology for dealing with the split of directs and indirects or some question about, for example, whether indirects should be allocated across

services based on direct expenses and work or whether it should be direct expenses and the time physicians spend providing services or what have you. So they put that on the list of refinement issues that will be dealt with next year.

The other point you made had to do with adjusting the conversion factor for budget neutrality. That issue has some twists and turns to it. Let me see how good I can do at trying to summarize what they are.

I think that the biggest issue there has to do with changes in work relative value units which occur as a result of the five year review that was conducted in 1996. The results of the five year review were essentially a net increase in work RVUs. As a result of review some work RVUs went down, some went up, but the net effect was to increase the work RVUs.

So HCFA had to somehow maintain the budget neutrality of those shifts. They did so for their first couple of years by applying an across-the-board minus 8.3 percent adjustment in all work RVUs in the fee schedule. The problem with that is that it does introduce some distortions because it affects the relationship between the three components of the fee schedule, work, malpractice PLI expense, and practice expense.

So HCFA has been criticized for doing that. So this year they said okay fine, we won't do that anymore. We'll take it out on the conversion factor and we'll apply an adjustment to the conversion factor to get us away from that adjustment to the work RVUs. So what you see then, reflected in the conversion factor for this year, is while we have a 2.3 percent increase in the update, the actual conversion factor has gone down by about $2. That's because of this budget neutrality adjustment that previously was taken out and work that's now been an across-the-board adjustment in the conversion factor.

I don't know what else to say about that. If you feel there's an issue here...

DR. LEWERS: Well, I think it's important to point out that while it looks like there's a 2 percent increase, or 2.3 percent increase, actually there's a decrease. And so when you take all those factors into consideration, I don't know that that's been pointed out. But we can talk about that as you see, I can talk privately with you.

If I might, Gail, just comment on the SGR, because that is based on the number that they're projecting that are going to be signing up. Now we've got programs pulling out, that we talked about the last time with Medicare. I think that the SGR projections occurred before the availability of plans were occurring. So whether or not that's going to have an impact, and how, and I just think that at some point we may want to make a comment on that because of what is that impact? Is the SGR appropriate? And the fact that we don't know -- while there's 60 plans, I understand, who are signing up, they're not up yet. So is that going to impact on where the SGR is going to go?

And then my final point is I agree completely with what I think I heard you say, we ought to put everything on the same basis, either the fiscal year or the calendar year. It doesn't make sense to me that we're doing that and I think we ought to comment on that.

DR. WILENSKY: I think at the very least -- at least if anyone disagrees it would be helpful if they indicate that.

I think we ought to suggest that they need, if they don't already have, the ability to correct for errors in estimates. I don't know whether they have correctly estimated the number who will leave traditional Medicare. But if they get it right, it's not going to be right other years. And the likelihood of having it be wrong seems substantial in this year because of all the flux in terms of the enrollment of these plans.

So that it becomes very important that they be able to make adjustments for errors in projections. I would assume there would be no objection to having that also be part of our recommendation.

DR. NEWHOUSE: We do it for hospitals.

DR. WILENSKY: That's why it's hard to imagine why one would object to making adjustment for errors.

DR. CURRERI: Kevin, can I just ask you, somewhere it seems to me -- either in the law or the proposed rule -- there was something about relooking at the SGR at six months after the first data comes in. Am I completely off base or is that something else?

DR. HAYES: In this rule or previously?

DR. CURRERI: I don't have any idea. It just came to my head and I thought...

[Laughter.]

DR. HAYES: I think what you're referring to is something I kind of glossed over in my presentation, and that is the idea that the update adjustment factor in the SGR, the thing that compares actual expenditures to allowed expenditures is calculated for a year but it's a year that ends on March 31st. The idea behind using that kind of a year was that it allowed use of data for the most recent time period available.

So while that was a good idea, the problem with it is it just exacerbates this mismatches problem, where we got the fiscal year, we got the calendar year, and now we've got this other year. So that's what you're thinking about probably.

DR. ROWE: Kevin, first of all, let me thank you for the clarity of your presentation here. You've convinced me you understand this. It means there's at least one of us in the room that understands this. I think it's very complex and potentially contentious. What appears to be happening may not be what's really happening, which I think is a concern.

I wanted to ask about this volume adjustment because, in response to one of Ted's comments, you said that as the volume goes up there's a kind of feedback mechanism where the prices goes

down or the payment goes down to compensate. I was wondering whether that volume, that adjustment takes into account -- just for my information. Does it take into account need, like increased number of Medicare beneficiaries or changes in their age or something like that? Or is it just services provided by providers? Physicians in this case.

DR. HAYES: The sustainable growth rate, let me just skim over the components of it again. It's changes in fees, changes in real GDP per capita, changes in enrollment and changes due to laws and regulations.

DR. ROWE: Enrollment is total number or is it age distribution? Obviously, people over a certain age might be increasing in numbers, where total enrollment might be decreasing in numbers. As we get 65 years past the depression, you know the birth rate fell during the depression. So the total number of people entering 65 and older is actually declining, I think. But the group is aging, per se so that there's a change in the profile. And the older you are the much more utilization you have.

So I'm wondering whether we're correcting for that. I heard you say total enrollment.

DR. HAYES: It is total enrollment. So one thing that this group has talked about is this matter of the real GDP per capita measure in the SGR. That is the component of the SGR which is intended to allow expenditures to grow for changes in medical practice, for changes in the volume and intensity of services that beneficiaries receive.

So the question is whether or not that's the right factor to use there. Does it adequately address the shifts that you're talking about in beneficiary need?

What I think you're arguing for is something almost like -- isn't it kind of like risk adjustment that we do for our managed care --

DR. ROWE: Based on age. The facts are that what we're going to have, I think -- one of the main things I'm not is a demographer. It's like Ed Koch every day had another idea what he wasn't. I'm not a this, I'm not a that.

I'm not a demographer, but my understanding is that this is not a one year phenomenon. That for several years, maybe eight or 10 years, there's going to be sort of a relative flat line or actually a decrease in the number of people over 65 in this country. Then it really starts to pick up when Gail and I and all the rest of us become 65.

Since it's not a one year phenomenon, we could have an effect over the course of several years that would be substantial with respect to this. I guess I would like to have some weighted number which says what's the average of the average beneficiary or something like the age of the average beneficiary, and modify it according to that.

I think we should at least comment on that.

DR. ROSS: We can certainly look into that, Jack, although one thing -- and I haven't broken it down for physicians per se, but if you look at Part B spending by age it, in fact, varies very little. Most of the age related spending occurs on the facility side.

DR. ROWE: Right, I see. That's interesting, Murray.

DR. ROSS: But that's for Part B as a whole, I haven't looked it. Kevin and I can chat on for physician specifically. It may even matter by specialty.

DR. ROWE: And there aren't data that with advancing age there's actually a reduction in the total Medicare expenditures for each additional data.

But I think we should at least look at this because it's going to be a phenomenon where there are shifts within the population that are not reflected by the total population over the course of eight or 10

years. And if there's no adjustment required or a downward adjustment, I mean it is what it is, we should at least not neglect it.

DR. WILENSKY: Again, I think people remember, this was not our recommendation that it be a flat GDP. We had suggested plus one or two to allow for a little bit more flexibility in the system.

DR. NEWHOUSE: I was going to support Jack's idea and note that we do adjust explicitly the AAPCC ages in there, and we're adjusting the number of beneficiaries in the formula. So it would seem consistent that since we're accounting for age on the at-risk side of the equation, that we would account for it on the other side of the equation, as well.

My recollection is similar to Murray's. I don't think it makes that much of a difference but that's not a reason not to do it. It would be a straightforward fix.

MR. MacBAIN: I just wanted to underscore a comment that Gail made earlier. Incorporating assumptions Medicare+Choice enrollment is another area for error. If Medicare+Choice turns out to be a flop next year this sustainable growth rate will be higher for that reason alone. You try to incorporate that into a physician fee schedule, logically it's just not defensible.

The less defensible it is, the more difficult it's going to be to achieve the desired outcome. It's no longer an incentive, it's simply a random number that comes out of the sky.

DR. NEWHOUSE: Anybody else want to comment on this? Kevin, do you want to ask any final questions before we close this section?

DR. HAYES: I guess the key question is, do you want to comment on these refinement issues? If we do so, this would be a letter which addresses both the refinement process as well as the professional liability insurance expenses.

DR. WILENSKY: I think the answer is, we would.

DR. HAYES: Fine.

DR. CURRERI: Could I see if I could get some agreement? I feel pretty strongly that the RUC system has worked very well and I think it's worked very well because it's kept the line of communications open between HCFA and the people that it's affecting.

I don't know whether this commission is willing to do this, but I really think that if we can keep a similar type system working on this aspect, I would be really all for it because it keeps things constant, rather than an independent contract or something else and you have to go through a third party and argue all those points.

If we're agreeable to that, I would like to see that in a comment.

DR. HAYES: Could I then just ask one clarifying, follow-up question? I indicated in one of the slides that there's some expertise required here in the area of things like accounting and survey research methods and so on. So one approach to this would be what? HCFA kind of relies on contractors to draw in that expertise. And then the RUC sort of serves as a forum for review of what comes out of that kind of process?

DR. WILENSKY: Bill, it seems to me you were a little bit more open as to whether it ought to be one of the advisory committees or the RUC. Whether it's exactly the same advisory process that's used, because it does seem that there are some additional skills that you may want to have in here that you might not need elsewhere.

DR. CURRERI: Ted could comment on this because he's much more familiar with it, but my guess is that within the ALA organization they have all these skills, but I'm not sure.

DR. LEWERS: They certainly have them. I don't know if HCFA wants to use them. And the PEAC is part of that process and certainly they are forming that. Kevin is right, the chair has been

appointed, and will do an outstanding job, Jean Agrew from California is going to be the chair of that. They certainly have all that expertise but it depends on...

DR. CURRERI: To answer your question, I'm not rigid about it, it's just that I think that there needs to be this open communication which seems to have worked very well because problems can be brought up to HCFA and be considered. Whether HCFA accepts them or not, that's gotten along pretty well.

DR. WILENSKY: We can be slightly agnostic in terms of the particular organization structure they use, citing something like the RUC, either exactly the RUC or a process like the practicing physician advisory committee, but to make sure that the people with the needed expertise and survey methodology are included. And whether it's precisely the RUC augmented by AMA individuals knowledgeable about -- I'm not sure we need to care about that.

DR. KEMPER: If I were in HCFA's shoes I would want to have at least potential contractor availability for some of these technical issues to support the effort.

DR. WILENSKY: HCFA doesn't need our permission to do that.

DR. KEMPER: It seems strange to be saying they shouldn't do that. But to say affirmatively that they ought to be involving something of the PEAC. That's what seems strange to me is alternatives.

DR. WILENSKY: I guess as I heard the point that Bill was making, it was both having the ongoing dialogue and having something as comparable to what exists for the work value activity as possible. Which would mean not really having this just as a -- well, it means not primarily or exclusively relying on contract. So whether or not they have contract support is a different thing, but that they have a way to have ongoing dialogue and in as comparable way as makes sense.

DR. WILENSKY: Thank you, Kevin. Sarah and Tim?

MR. GREENE: I'm talking today about several programs that Congress and HCFA have established providing tests for various models of care for the frail elderly. I'll be going briefly over the programs, then reviewing MedPAC responsibilities in this area, past MedPAC work, and then several policy questions that we've identified and a workplan for further work in this area.

The questions for the Commission are several. First, we need your feedback in a number of areas. We've identified significant policy questions which the Secretary and Congress will have to consider to decide whether and how current demonstration programs could be made permanent and how both demonstrations and permanent programs can be made consistent are the questions we've identified, the correct questions from your point of view.

Second, we've presented background information on care for the disabled and frail elderly in mailing material in last March and last June's report and in other presentations. We hope to hear from you, if you wish further background information for your deliberations, or if you wish more in-depth discussion and material we've presented so far.

Third, the mail material presents and Sarah will be discussing a workplan for analyses of these programs and issues. Since we cannot complete all items in the workplan with current resources and in time for the June 1999 report deadline, we hope that you can guide us with your priorities on these matters.

First, I'll review briefly the models of care that we'll be discussing this morning. First is a social health maintenance organization, both first and second generation. The first generation is referred to affectionately as SHMO I and the second is SHMO II.

The first generation program tests the model of service delivery and finance and it's supposed to integrate long-term care and acute care and social services. Congress mandated the demonstration in 1984 and has renewed it four times. It's now scheduled to expire December 31st, 2000.

The second, SHMO II, demonstration is supposed to improve on the first generation plans and to provide better service financing methodologies and benefit design. It will also increase emphasis on geriatric care, expand case management and improve risk adjustment in payment scheme. Congress mandated this expansion of first generation demonstration in 1990 and has renewed it twice. It, too, is not scheduled to end December 31st, 2000.

Third is program of all-inclusive care for the elderly, PACE. This is designed to keep frail elders out of nursing homes. Enrollees must be eligible for nursing home placement and generally are Medicare eligible. Congress mandated this demonstration in 1986 and renewed it twice. The Balanced Budget Act of 1997 has made it a permanent part of the Medicare program and a state option under Medicaid.

Finally, Evercare is a demonstration that seeks to manage acute care of permanent nursing home residents by pairing geriatric nurse practitioners with physicians. The demonstration is intended to improve care and reduce use of hospitals and emergency rooms. HCFA granted Medicare waivers for the demonstration in 1994.

Note that the status of the program differs. Although SHMO I and SHMO II remain demonstrations, the Congress required in the BBA that HCFA report on how to convert them into permanent programs. In the BBA, Congress has already made PACE a permanent program in Medicare. Finally, Evercare remains a demonstration and its future is uncertain.

Turning to MedPAC responsibilities in this area, they differ greatly between the four programs. First, with regard to SHMO I and SHMO II, you have no mandated responsibilities. However, you may wish to comment on a report to Congress mandated on the Secretary for 1999, due formally January 1, 1999 and expected now in the fall. This is a report that will lay out a plan for converting the SHMO demonstrations into a permanent part of the Medicare program.

With regard to PACE, the BBA does give the Commission several mandated responsibilities. You have to make annual recommendations as far as Medicare and Medicaid payment amounts and methodologies. The Commission must also comment on the appropriateness of allowing private for-profit entities to participate in PACE. BBA authorizes a demonstration for for-profit sponsorship of PACE sites but the demonstration has not begun yet.

Finally, with regard to Evercare, the Commission has no mandated responsibilities.

The Commission has done work on frail elderly and disabled in a number of work products so far. In the March of 1998 report, you included a chapter describing the PACE program. In the June 1998 report you had a chapter discussing managed care for the disabled elderly and the chronically ill, which are basically groups that overlap significantly with the frail elderly.

The question now is for the June 1999 report what material you want to include. We could include discussions of the social and health maintenance organizations, the demonstrations, the first or second or whatever, or all of the four programs that we'll be discussing today, the SHMO I, SHMO II, PACE and Evercare programs. It's up to you, what we can move on to include next June.

Key policy questions that have arisen that we've identified really begin with a basic question to be considered before we turn to anything, which is how can these programs, both demonstration and PACE, be made consistent with each other and with the Medicare+Choice program? And should the demonstrations, SHMO I, SHMO II and Evercare be made permanent? To decide on those matters Congress and the Secretary will have to consider several specific questions.

First, what additional value to beneficiaries get from participating in any one of these programs? Possible benefits to beneficiaries could include better outcomes such as improved satisfaction and improvements in or arrested decline in functional status, and better coverage with less out-of-pocket payments.

Second, if there are additional values identified for beneficiaries, what desirable features of these programs could be incorporated into the permanent Medicare+Choice program? The Medicare program could require or encourage Medicare+Choice plans to adopt specific features of these demonstrations or plans could choose on their own to voluntarily adopt features of their choosing for their frail elderly members living in nursing homes or in the community.

Third, if these programs remain separate, should they be subject to all or some of the Medicare+Choice standards? Medicare+Choice standards are designed to protect beneficiaries. Several exceptions might be warranted, at least for PACE and Evercare, which have relatively few healthy beneficiaries as members. The requirement, for example, to survey enrollees using the Health of Seniors self report of health status might be inappropriate for the functionally disabled and, in some cases, cognitively impaired population. HCFA might wish to identify alternative and more appropriate quality instruments in dealing with the population.

Second, the limits on enrollment and disenrollment which will eventually go into effect might inappropriately lock beneficiaries into some specialized plans or exclude them from others. For example, it makes no sense for a beneficiary leaving a nursing home to wait until the next open enrollment period to leave Evercare. While on the other hand, a beneficiary who may be soon eligible for a nursing home may want to enter a PACE program and not be able to if he were limited to the enrollment and disenrollment rules.

Finally, alternative forms of information dissemination might be necessary to assist functionally disabled or cognitively impaired beneficiaries to choose the plan most appropriate to them.

Finally, what is the most appropriate payment method for these plans? Programs for the frail elderly base payment rates on the Medicare+Choice amounts but have varied approaches to reflect these

population's risk for using services. We discuss those in greater length both in the mailing material and in the appendix material.

On the other hand, the risk adjustment system proposed for Medicare+Choice, the DCG system, takes health status into account, reflecting diagnoses in service use. HCFA has been studying whether the diagnosis based system is appropriate for the SHMO, PACE and Evercare populations.

The risk adjustment system may not perform adequately when programs are tailored to a small, sicker than average, subset of the Medicare population. But this is a question that requires empirical study and evaluation.

For the time being, HCFA will likely exempt SHMOs, PACE, and Evercare from the new risk adjustment system and continue to pay them using their old formulas. MedPAC may want to think about potential ways of adjusting the risk adjustment system for these populations and the implications of different approaches this may have across programs.

Sarah will now discuss the workplan items that we've identified.

MS. THOMAS: I'm now going to go over the projects that Tim and I have thought up that we hope will tell us more about the value of these programs, the standards that should be applied, and the appropriate payment method. They're also a few assignments the Commission could take on to provide HCFA advice on what to do with these programs, and also how to incorporate the experiences from these programs into Medicare+Choice.

First are a set of projects that would try to get at the question of what value these programs offer their enrollees. The Medicare+Choice performance measures like HEDIS may be appropriate for the SHMO population who's not nursing home certifiable. But the populations who need long-term care probably

have conditions or health care problems that are prevalent in these groups but not so common in the general population.

The focus of this project would be to identify the best outcomes measures. HCFA has funded the University of Colorado Center for Health Services and Policy Research to identify outcomes measures for PACE. We will monitor this work and also review the literature to find measures that might be appropriate for populations like those in Evercare who live in nursing homes.

A fairly simple analysis would be to compare the benefit structures across the four programs and compare them to those offered by Medicare+Choice plans. We'd also want to look at patterns of Medicare service use by nursing home residents to understand where opportunities to reduce hospital care might be.

Second is a chance for MedPAC to weigh in on the future of these programs and standards. Staff will look at HCFA reports on the SHMO demonstration and its plan for the future of the program next year. The PACE regulations are supposed to be coming along soon. They'll probably come out in the next few months, so we can look at any issues there and comment if you wish or present Commission views in the June report.

Finally, we will look at payment in particular on what the best performing and most feasible method of risk adjusting payments might be. The mortality rates on page two in your mailing materials provide some evidence on the differences in the burden of illness across these programs. If you think the information would be valuable, we can calculate pre-enrollment spending and service use much as PPRC did for the risk program to get better inferences on risk selection differences.

We'll spend some time looking at potential candidates for risk adjustment and, depending on the data availability, we can model the impact of different methods including the one that will be used for Medicare+Choice plans in 2000 and 2003. We also want to take a look at the types of services used by the

functionally disabled to see whether a large share of the spending differences might be accounted for by post-acute services or whether these folks simply use more of all kinds of services.

Leonard Gruenberg of Datachron in Massachusetts is working on a study for the SHMO, PACE and Evercare plans and formed a coalition on this issue that will make a case that we think that the current payment adjusters for the programs are appropriate and that no changes should be made until a better system is developed. We'll certainly take a look at the details of that study and we'll take a look at the Abt study on savings from PACE to Medicaid.

Any suggestions you might have on additional Medicaid projects would be very helpful.

At this point I'd like to turn over the discussion of the workplan and other issues that Tim raised to you. What else do you feel you need to know to make recommendations on these programs? Or which programs do you want us to consider overall?

DR. WILENSKY: Thank you.

MS. ROSENBLATT: I guess one of the comments I have is on the risk adjustment. There seems to be so much concern right now about risk adjustment in general that the level of concern I think would be very heightened when you're talking about small populations like this, so I think it would be real important if we could come out with a recommendation saying maybe risk adjustment for this type of population, we're just not ready for it, the methods aren't ready for it, there are real credibility issues.

From what I know, when you've got populations that are biased towards illness, most risk adjustment methods out there today definitely under-predict expenditures. So I think if we could do some studies that would get us to that type of recommendation it would be helpful.

MS. NEWPORT: I'm going to confine my comments to the social HMOs because I feel a little more comfortable with what's going on there, in one way. But on the social HMOs, there's a stage I and a

stage II. The stage II basically was updated to look at a more refined, if you will, payment method. But the stage I, are they still staying with the old payment method or was their payment updated under the stage II?

MR. GREENE: They're staying with the old payment method.

MS. NEWPORT: The last time there was any kind of definitive study of social HMO I was in '88; is that correct?

MR. GREENE: The evaluation has been ongoing since, a number of published papers have come out, HCFA published an internally constructed staff summary in 1996 and a final evaluation report is due out --

MS. NEWPORT: Any moment?

MR. GREENE: Legislation says March 2000. We thought it was coming out earlier than that.

MS. NEWPORT: I guess the concerns I have are sort of broad and one of the things -- I agreed with your questions that you've raised. What is the value added for beneficiaries? Then how is this going to be incorporated into the Medicare+Choice program? Is it going to be generally available or are we going to institutionalize, if you will, just a small subset of plans?

I think that if there's value I would argue that the value should be available to all beneficiaries, as opposed to selected sites. I don't know the answer to that question but I'm suggesting, in terms of equity in the program, that that be something that we recommend if it's going the other direction.

I guess I'd echo Alice's concerns about risk adjustment in this population, in population of sites or population of demonstrations, that I would be very concerned since risk adjustment right now is based on inpatient data collection, there seems to be some skewing there or potential skewing of payment.

But I would also say that I'm a little interested, too, in the effect on the traditional payment side as opposed to the BBA payment. Are we going to get different results from that? Because we will be sort of codifying, if you will, an old payment schedule as opposed to trying to see what effect the new payment system would have on these plans. Again, I don't know the answer to that question but I think it's something worth thinking about.

Then the variability, as I understand it, in terms of nursing home certification is based on Medicaid law in the states; is that correct?

MS. THOMAS: That's correct.

MS. NEWPORT: Do we have the ability to measure what distinctions might be imbedded from state to state in that, and what affect that might have?

MS. THOMAS: We did a little review of the types of different nursing home certification requirements in last year's March report. And we certainly could expand on that.

I also think that HCFA did contract with a research group to take a look at what the implications of those variations might have on the level of risk, in PACE anyway. We can certainly track that down and see where they are.

MS. NEWPORT: Then I guess I'm not clear in the issue of conversion to Medicare+Choice what Congress' intent might have been, or was it just we've demonstrated this since 1984, it's time to change over? Have you had any clarity on what their thought processes might have been, or not, on that?

MR. GREENE: Not in great detail. The language of the legislation is straightforward about producing a plan. The conference committee report is fairly emphatic that though the legislation simply left it open, that all resources previously put into testing the program should be put into shifting SHMO and similar

programs to permanent program status. So they haven't laid anything down, they haven't said anything detail, but it's gotten a strong message through that they want to convert SHMOs into permanent programs.

The suggestion is, though again it's not explicit, that those being the existing SHMO sites would be made permanent. But it's unclear whether they mean --

MS. NEWPORT: Or that they could be expanded to --

MR. GREENE: I guess the suggestion is that we make it a benefit available to all beneficiaries would seem to suggest they want to expand beyond the current sites.

MS. NEWPORT: The answer to that could be very interesting in terms of direction for the program, too, if this is made available only on a limited basis or made available as an addition to existing programs.

MR. MacBAIN: Back to the question of risk adjustment. The notion of using a risk adjuster that's based solely on inpatient diagnosis seems to me antithetical to the whole objective of both of these programs. Just taking what's in the paper here, the objective of the SHMO is to integrate acute and long-term care. To pay on the basis only of acute admissions will push that in the opposite direction. And similarly with PACE, to avoid institutionalized care for frail community residents means that you'll be paid in inverse proportion to the degree of your success in achieving the program objectives.

So I'd like to see it worded a bit more strongly, that the current inpatient approach is flawed enough for the Medicare+Choice population as a hole. But trying to apply it to this population would destroy it. I think that's fairly strong.

MR. SHEA: In your workplan you make the point about looking at outcomes measures. But in the paper I get the sense that the studies that have been done in the evaluation so far are, at best, early if not

inconclusive. It seems like we're talking about a big decision here without, again my sense from the paper, without really an awful lot of information on which to base a decision.

MS. THOMAS: I think that that's correct. There are much better measures that you could use now, better tools to take a look at outcomes. They looked at a fairly simple set of outcomes and their results were inclusive.

MR. SHEA: I thought one of your statements in the paper, which I liked quite a bit in terms of framing the issue generally, but one of your statements was to the effect that you need to look at if there are, in fact, improvements and therefore this is something with some added value, you need to identify where do the improvements come from in terms of actually moving this along.

And then lastly, just so I'm clear, when the legislation talks about mainstreaming this I assumed that meant, in some fashion, making this as a broad option in addition to traditional fee-for-service; right? The fee-for-service will always remain, obviously.

DR. WILENSKY: That's presumably, if you were going to make this more widely available, what you would do.

DR. ROWE: A couple comments. I think that when it is made more broadly available, technology such as this, like new medicines or any other technologies are less effective in general than they are in the demonstration projects. The group of people who came forward, whether it was Onloc or who it was at first in the PACE demonstrations -- which are very small in number, you know there's 10 or 12 of them and there are a couple of hundred patients in each of them. These are little boutiques, the best and the brightest in geriatric care around the country. I just think it's very dangerous to take that experience and then generalize to a Medicare+Choice or any other Medicare population. We should be aware of that, I think.

I don't know how to compensate that, but we should take that into account a little bit in the pricing. And I don't know if that's going to increase the price or decrease the price, but I think we should just think about it.

The second thing about the pricing is I think before we get to the risk adjustment, and I agree with the absurdity of the inpatient basis, we should decide what we want this thing to cost. I think, with respect to the PACE program, there was an intention, as I recall, to have this sort of be budget neutral. That is, the idea was we're going to wind up incenting people to give more outpatient care and social services and other care. And the costs associated with that are going to be compensated for by reductions in inpatient care and it will be budget neutral and we're happy with that. That was the assumption in the beginning.

DR. WILENSKY: It's really reductions for PACE because it's Medicaid eligible nursing home. It was really the reduction in nursing home overall costs.

DR. ROWE: Overall costs then would go down.

DR. WILENSKY: I mean inpatient, also.

MS. THOMAS: Actually, inpatient also. In fact, one of the directors of one of the PACE programs said that's where they get their biggest savings.

DR. ROWE: So I think a discussion that HCFA should have, or maybe we should help them with, is what do we want this to cost, before we get to how we're going to adjust the risk. That is, if we can demonstrate increased quality in reasonable outcomes -- not mortality rate. I mean, it's like studying a mortality rate in a palliative care program, a hospice program. Mortality didn't fall, the program must not be any good.

If we can find some reasonable sensitive outcomes that are concordant with our goals and we can show an increase in quality, maybe we would be willing to pay a percent or two or whatever more for that care for this generally neglected and not particularly well taken care of subset of the population. Maybe not.

But we should sort of decide that, because the way it is now, if I understand the White study from Abt and Cambridge, was that these programs are getting paid somewhere between one-sixth and one-third less than they would if the patients were in traditional Medicare and they didn't have these programs, but the patients were still in their system of care. So that's a very strong disincentive to have a PACE program, and it's going to put these programs out of business very quickly unless some other approach is taken, I think.

DR. WILENSKY: Let me just make a suggestion with regard -- I don't know if we'll be in a position to know this, so it would be a hypothetical statement. To the extent we could share with Congress our assessment that you could have, in a budget neutral world, better outcomes and better quality is one statement. But it may also be possible to say that in order to get better outcomes it would require a positive spending, not a budget neutral relative to either Medicare or Medicare plus Medicaid.

I don't know that it's particularly our place to say we should have that expenditure, but I think it would be certainly a value to say either at a budget neutral level here's what we think you could produce in terms of outcomes and satisfaction. And in order to do something else, here's something about the additional cost that might occur. That would at least give the Congress, if we were in a position to say that, the information to decide whether or not there was a willingness to put additional funds into the program.

DR. ROWE: And if they're specific about the intent with respect to the payment, then that would urge some sort of post hoc correction, if they've overpaid or underpaid or whatever so they can get to it. Otherwise, the way they are now, if somebody came to somebody in my position and said look, we've got a great idea to take 250 of our most frail elderly and put them in this program and we're only going to lose 30 percent on it, compared to what we're getting as it is now. There's not a great incentive to do it. Might do it anyway, but it's not a great incentive to do it.

DR. WILENSKY: There may be at least an ability to comment on the numbers issue that Jack had raised, which is to the extent that there's been self-selection among providers -- which I think is probably correct -- it would mean that it would be hard to replicate even the results you're having now, which appear to be quite equivocal.

DR. ROWE: That's right. My guess would be that it's going to be very hard to -- you're not going to find another 12 sites that will do as well. That's nowhere in the material.

The last comment I had has to do with this is -- and I think it's relevant to the comment that Gail made about Medicaid. This is very much, we're looking at half of a two piece program here. And the Medicare program is pretty constant across the United States. But the Medicaid program is very variable.

So I think the success or the relevance of the PACE programs really varies across states because in states in which there is what's perceived to be a very rich Medicaid program the patients don't see any added benefits to the PACE program because they get all these other services anyway. So there's less incentive for the patients to go in, and vice versa in the states with the less robust Medicaid program.

So I think that we might comment on that a little bit, about that interaction.

DR. KEMPER: I'd first, just to mention that this is a nice comparison and presentation of these programs and pulling together a lot in a short space. I think that's particularly useful because they do have some things in common even though they do have very different histories and so on. There will probably be other demonstrations in Medicare that come along where these same kinds of issues of integration with the regular program come up. So I think that's really useful.

I would suggest that you focus the analysis on the payment issues and risk adjustment and on the issues of what it would mean to integrate them in Medicare+Choice. These are the kinds of innovations, I

think, Congress had in mind by having Medicare+Choice kind of program and consumer choice. These didn't come from that initiative, but they're the kind of innovations that one might hope for.

It seems to me that while I agree with Bill and Alice on risk adjustment as its currently laid out isn't going to do very well on this group, it seems to me that the long run objective ought to be to try to develop risk adjustment that would deal with it. In fact, it's impossible not to deal with what Jack called the payment issue and what Alice called the risk adjustment issue. As I understand it, PACE gets 2.3 times. So there's risk adjustment right there. It's not that it can be put off, it's right in all these programs.

So I would argue we ought to really focus attention on that issue and try to figure out what to do about it, not next year but five years from now.

It seems to me the issue is should other types of plans be able to get that same payment rate to pursue some other different kinds of innovations. If that is, in fact, a true reflection of the Medicare contribution in costs, then it seems to me that other kinds of plans might be entitled to that payment for similar patients to come up with potentially different kinds of innovations.

I guess one question I had about your paper was you at one point -- it's actually on page nine -- mention that the programs should be discontinued or folded in to Medicare+Choice if they offer little additional value to beneficiaries. I wouldn't necessarily equate folding them into Medicare+Choice with discontinuing them.

I would almost view it as making them permanent because if they're incorporated in the Medicare+Choice then all kinds of organizations could spring up, Jack's point notwithstanding. There may not be lots of plans out there that could do this. But at least in principle, rather than discontinuing them, it seems to me it's really opening up the opportunity for expanding them if they're brought into the Medicare+Choice.

I think there's risk to the program if we start proliferating lots of special programs with lots of unique payment rates which, over time it's going to be impossible to know whether those payment rates really bear any relationship to what the Medicare contribution would have been generally.

DR. NEWHOUSE: I have a hopelessly broad and a very narrow comment, so maybe the average will be okay if you don't like the two comments.

The hopelessly broad one is an issue about how to frame this question which goes considerably beyond our charge. To me when I read this, you start out the primary policy question is whether Medicare should continue to make these programs available. These programs, to me, are the proverbial camel's nose in the tent. That is, they generally raise the issue of integrating long-term care benefits and acute care benefits, which you kind of start out here but then don't really continue very much with.

I think it probably important to start out by saying that the country is going to probably be grappling with that issue for the next many years. And that it really raises the issue of how to integrate Medicare and Medicaid benefits. These programs are just tiny but the issue is enormous. They're kind of a little, almost distant early warning system. But the problems are there and they're going to get worse.

So I guess I'd like to start out by framing the issue that way, and just to alert people that this is just a little piece of the issue.

Then the very narrow comment is I was struck by your comment about using the self report of health status as a risk adjuster and that this may not work very well for cognitively-impaired people. The issue that raised for me is if that's true -- and I don't know what the evidence is there -- this has got to be a problem, in general, on the at-risk program. Again, there are such a tiny number of beneficiaries in these programs, just on the sheer size of it there have to be more cognitively-impaired people in the regular at-risk program.

What are we doing or what is HCFA doing there with their risk adjustment instrument? I didn't know the answer to that question. I'd never thought about it before.

MS. THOMAS: Just to clarify. I think that the discussion of self-reported health status is more for measuring functional status and changes over time, not necessarily that it would be used for payment, but to gauge plan performance.

DR. NEWHOUSE: But isn't Health of Seniors mandated for all at risk enrollees?

MS. THOMAS: Yes, absolutely. But it wouldn't be used for payment. It would be more to measure plan performance.

DR. NEWHOUSE: But there's still an issue.

MS. THOMAS: It's definitely a cross-cutting issue. Definitely.

DR. NEWHOUSE: You're raising the issue of maybe this isn't suitable for this small population but that comment has broader implications.

MS. THOMAS: Agreed.

DR. CURRERI: You asked us to try to give you what our ideas of priorities were, in terms of where you should go. I must say, I had the same problem when I read this paper -- and no criticism of the paper -- as Gerald had. That is that there seemed to be not enough data available at the present time to make a lot of the decisions that you're sort of asking us to do in the future.

So the way I looked at it pretty simplistically was that Congress has decided there is value added in the PACE program and they have put it in there, and therefore that ought to be our number one priority, is looking at quality, outcomes, and so forth in the PACE program.

SHMO I, according to the literature, had no value added at all. And we don't have any idea about SHMO II, so I think we ought to just do nothing with SHMO II until it's time to critique at the end of the

demonstration. Because if it turns out there's nothing value added in SHMO II, we've wasted an awful lot of energy.

Evercare, I would put in the third priority because it's sort of just in limbo at the present time. Unless there's some serious feeling that Congress is going to incorporate this, I think we ought to just observe what's happening in that program and not put a lot of effort into trying to evaluate it.

MS. NEWPORT: Just a quick timing comment. This again is on the SHMOs as opposed to the other programs. I think that we need to be sensitive, and Congress needs to be sensitive as well to enrollment growth in these plans, and if there's some acute change that happens you can have a pretty interesting impact, if you will, on the populations that are enrolled. So I think we need to exercise some caution.

Which goes to, I guess, quality, the cost, et cetera, in terms of what our recommendations are. If there's value added, great. But if there's not and there's a distinction made that there's no value, then why are we perpetuating programs that we're allowing to grow at the same time? I think we need to make sure that we're not sending the inappropriate signals. And when I say we, that's a global policy we.

There's a cap?

MR. GREENE: Yes, the BBA increased the cap and it's now 36,000 per site.

MS. NEWPORT: I think that goes to a lot of subtext to a lot of comments here, but I think we need to be pretty explicit about if there's a general dissatisfaction with one type of program we need to be cautious about the effect.

MR. MacBAIN: I just wanted to go back to comments by both Peter and Jack earlier. That is I appreciate Peter's comments on the risk adjuster and completely agree there needs to be something, just not the inpatient.

But I don't want us to focus just on the cost side of this, because there's a clinical issue and Jack can speak to this a lot better than I, is this whole question of as we continue to have more frail elderly with more simultaneous complex chronic conditions the existing approach to caring for them is, as I perceive it, not adequate particularly in a lot of areas of the country. Certainly in rural areas, inner city areas and probably a lot of metropolitan areas.

What we've got here is the beginning of what could be a series of experiments to try to find better ways of dealing with this population, which is going to just keep growing.

What is missing I think is that these were set up more as a political outcome rather than as a scientific investigation. I don't think they were set up specifically with the end in mind of what are we going to measure, when are we going to measure it, and what sorts of feedback are we going to use? Are we going to allow modification of the programs based on measurements? That kind of thing.

Would it be appropriate for us to add a comment on that in the June report, how we might take this beginning and craft it a little bit differently, to really try to use a few federal dollars to encourage this sort of experimentation and evaluation. To try to find the best clinical way of dealing with these problems.

Once we've got a better handle on clinical alternatives, then we can try to figure out which of those is the most cost effective. Jack is that a reasonable...

DR. ROWE: I agree with you. I think there is an intrinsic belief that hospitals are bad for old people, so that any program which reduced hospitalization was necessarily good.

I happen to believe that that is about as wrong as intrinsically that nursing homes are bad for old people. And that if you've seen one old person, you've seen one old person, particularly when they're really sick. So I think those kinds of measures are not the right kinds of measures.

DR. WILENSKY: We could certainly suggest doing experimentation to get better clinical outcomes. We certainly could suggest, with even greater expectation of a pickup, allowing more experimentation and a budget neutral as opposed to a cost saving environment. We can recommend, if the Commission wants, things which are positive costers. But we have to recognize that we come up with also recommendations about how to finance them, they're less likely to be viewed with seriousness.

But it does seem to me that because these are, in fact, less than it appears would otherwise have been spent so that there are savings associated, we certainly could make recommendations that HCFA allow more experimentation with particular emphasis on clinical outcomes and satisfaction, as long as there was a likelihood that they would be budget neutral.

MR. MacBAIN: Just a follow-up question on the savings in the PACE program. I haven't read the study.

As I understand though from the paper, the control group were people who had elected themselves not to complete the enrollment process, which makes them a self-selected sample. Are there other aspects of that study that control for the effects of that selection that could otherwise skew the results?

MS. THOMAS: Yes, the one, Carol Irving, was the predecessor, and she actually did look at the differences between the sample and the control. And then, when the later paper was said to look at the cost savings, those differences were controlled for. That did not apply to the earlier outcome study, though.

DR. ROSS: Just a quick clarifying question. On those savings, those were across Medicare and Medicaid combined?

MS. THOMAS: Just Medicare. The Medicaid work hasn't been completed yet. Just Medicare.

DR. KEMPER: Two comments. One is, Bill, your comments also are similar to comments about the care at the end of life and it seems like there's a package of related comments here.

The other is really a question. You mentioned doing analysis of Medicare costs and that piece of it. I agree with Joe, this is bringing together the long-term care piece and the acute care piece. How much ought the Commission to get involved in in looking at the Medicaid cost side of things?

DR. WILENSKY: Unlike PPRC, we do not have Medicaid as a charge to us. However, to the extent we are asked to look at these programs, it's hard not to get into that issue. I mean, we will have not a general assessment of responsibilities or of effectiveness of Medicaid, whereas PPRC was looking at physician participation in Medicaid and access and other broader measures. We will not do that, but I think it is appropriate with regard to this specific program to look at it as an overlapping responsibility.

MR. JOHNSON: Just sort of an off-the-wall comment, maybe to close this. We're sort of projecting current illnesses and current modalities of treatment into the future with a larger frail population. Somewhere in here there's a role of what happens with technology like pharmacological advancement which may or may not affect who the frail elderly are, how old people are living, genetic kind of activities.

Somewhere in here, it seems that we're just focusing in a disease element as opposed to also having somebody from a policy point of view looking at the advancement in these other areas, which may alleviate some of this or change the nature and change how things are delivered. That's sort of how many angels can dance on the head of a pin. But on the other hand, we're so focused on this stuff that somebody somewhere ought to look at the broader picture, as well.

DR. WILENSKY: I think, not for this year.

Thank you very much. Do you have enough direction?

David and Andy, moving on to the other similar issue that has been raised a couple of times, that is care at the end of life.

Jack, did you like the New York Times article on that nursing home that was on the front page?

DR. ROWE: In Seattle? Apparently they've hired her just to be like an aging or long-term care or something. She's done several articles. I thought it was excellent.

DR. WILENSKY: As did I. That clearly indicated, apropos your comment, that nursing homes are not necessarily bad. It was a very interesting, very long article on this one nursing home.

DR. ROWE: I think Bruce Vladeck was right 20

or 25 years ago when he wrote his book about nursing homes and how bad many of them were. But we've never recovered from the view. So every time you tell an older person they have to go to a nursing home, or you think they should go to a nursing home, you wind up with this terrible resistance, like you're sending them to their death or some terrible prison or something. It's just a view we have in this country, and it's just wrong.

DR. WILENSKY: Andy.

MR. COSGROVE: Thank you. Good morning, everyone, it's wonderful to be back in front of everyone again. I am going to present the first part of this outline and also the last part, and David, to my left, will have quite a bit to say in between.

I'm going to speak a little bit firstly about the challenges of providing high quality care at the end of life. There are a number of issues here that I know a lot of you are quite interested in. One big one is respecting the wishes of patient and family in this process of dying. Studies and surveys have shown there are problems in some areas. One of the big ones is that a lot of times an advance directive is not a part of the medical record. As such, the things can get lost in the hospital.

I think just interpersonal communication about dying and the end of life is maybe not as good as it could be. One survey that I looked at found that of patients who had filed an advance directive about 20 percent had actually changed their mind but had not notified providers or anything.

While we haven't found any extremely large, very scientifically rigorous studies of advance directives, there are a number of smaller studies out there that we intend to look at and summarize.

Another one, sensitivity toward culture and religious differences, I think that can kind of speak for itself. We all come from somewhere and we all have different mindsets and cultural identities and things that we are expecting towards the end of our life and things that we're not expecting. We can provide a summary of those.

Addressing emotional, spiritual and social needs, sort of comes in under the cultural thing, I believe.

Moving on, relieving symptoms including pain, pain is a big one. For this workplan, I think a review of literature on the extent of physical suffering during dying, the support study which is the big groundbreaking study in this field, said that there's plenty of that. Also, review literature on the effects of opioids prescribing laws and provider's fear of professional sanction and criminal prosecution.

Surveys of doctors have shown some trepidation to prescribe opioids and to prescribe analgesics, which are not quite as strong as opioids, in their place. I also describe reasons why other physical symptoms may not be treated adequately.

Another big issue is continuity and the coordination and comprehensiveness of care at the end of life. We intend to search literature, discontinuity of care and its effect on the patient. We know, I think, from some previous studies on I guess both commissions. There is a fair -- like with the post-acute care, it has been documented that it's just generally a bad thing.

We intend to look at claims files to analyze sites of care providers visited to like the numbers visited, the duration of these visits for a period six months prior to death, 12 months prior to death, to get a better handle on -- just to the extent of this problem.

I also want to describe palliative services that are not covered by the main Medicare benefit, which is strong opioid prescription drugs, the medical social services, things of that nature.

And now, ladies and gentleman, live to you from Palo Alto, California, David Shapiro.

DR. SHAPIRO: Thanks. The second section we propose would be on assessing the quality of palliative care. For providers to improve their performance it has to be measured, so this section will look at the state of the tools that we have to do this. Few, if any, of the standardized measures currently in use are applicable to palliative care, so we'll take a look at what's under development.

Anticipating that even that will not be sufficient for Medicare's needs, we anticipate that we'll need to look at how Medicare could stimulate the rapid development of the measures that it will need to use or want to use.

The third section we propose is on professional and medical education. We'll look at what needs to be taught and the extent to which it is being taught or tested in undergraduate programs, in licensing and certification exams, and in continuing medical education both for physicians and for non-physician providers.

The fourth section we suggest would be on improving the use of advance directives. There is a sizeable body of research now on advance directives and a small amount of it is actually even applicable to the important issues, so we'll try to synthesize some of that and draw whatever lessons we can and see how federal policy is currently embodied in the Patient Self-Determination Act of 1990 might be better directed.

The fifth section is on hospice benefit.

MR. COSGROVE: There was an appendix describing the hospice benefit in general at the end of this section. Hospice has not been presented to this commission formally, so I hope you saw that if you're not very familiar with the benefit.

A couple of things we wanted to do here, we thought we'd analyze hospice claim files and beneficiary data to describe the characteristics of hospices, their patients. There is the sense in some of the literature that hospice tends to be a white, middle-class, suburban phenomena. There are some possible reasons for this which I'll get right into.

We want to investigate barriers to access that may result from some of the structural -- what's the word I'm looking for -- the eligibility rules. The six month terminal illness diagnosis, which generally limits the patient base to something of a cancer model or something to where the patient's decline is fairly predictable and fairly rapid.

Also, there's the significant amount of informal care that hospice patients require for the most part. This actually results from a cap on inpatient care for hospice patients. The focus of the program is primarily to allow patients to be in a comfortable setting in their home for the end of life, but this also tends to require informal care at home.

We would look at ways to possibly expand this way of treatment and there are things that could be done, instituting a co-insurance for some home care, to extend that to people that don't have those ties and people to provide that.

Looking at Medicare+Choice and the hospice benefit, hospice as it stands is something of a managed care program right now and we would just present these to you.

I guess what we're looking for on this presentation is for your feedback on these projects, which ones seem a little more interesting than some others. And other questions you would have, other projects not listed here that we might do.

DR. WILENSKY: I'm a little surprised at some of the detail in terms of the education and training of physicians and nurses and others looking at curriculum. I don't know how others on the Commission feel, but I don't see that we bring a whole lot to the table.

I think it would be fine to say this is an issue that needs to be looked at, but I don't really see that this is an area of expertise for this commission. So it would seem to me that there are a number of areas that you've raised, particularly with regard to measuring quality and the integration with Medicare+Choice and advance directives, all of which strike me as having a lot that we might be able to say.

I'm a little uneasy about having this commission getting into curriculum review and areas like that. But my colleagues my feel differently about what we can usefully say, looking at textbooks, et cetera.

MR. COSGROVE: If I can just -- the focus, because we got the message loud and clear, I think, from previous meetings from this commission that the care of the dying is not an issue to have money squeezed out of. We know that most of the spending for people is in the last year of life and we had the sense that we're fine with that. Not to say that there's no issues of spending to look at, but...

DR. WILENSKY: That's a whole different area that we can take up if we want to, but this is really within the context of what you're suggesting. It just seems to me that again, this is an area that is so far beyond what I would regard our normal expertise that my own opinion is that we could bring more to the table by looking at some of the other issues that you've raised, although I think I'm perfectly comfortable with saying that this is an area that has been ignored, to the extent that it has been ignored, by the medical education system, it's important, it needs to be given additional attention.

As opposed to our getting into making recommendations or assessments about curricula and textbooks, et cetera.

DR. ROWE: Gerry wanted to know if I was going to rise to this bait. I don't want to get in a disagreement with our distinguished chair based on her extensive experience with medical curriculum, so I'll hold that for a later argument.

But in general I would say, Gail, I think that the question comes down to whether or not -- it's how we view the program. I mean, it's sort of like the GME question, too. I mean, what is the responsibility of the program? If the responsibility of the Medicare program is to try to assure that the health care capacity in the country can take care of the needs of Medicare beneficiaries, then it's a matter of not just the numbers of doctors and how many are primary care and how many are specialists, but whether they have the skills, they have been educated in such a way to in fact take care of the needs. And this may be, care at the end of life, one of the needs.

On the other hand, you can define it, you know, that's not necessarily telling them what textbook to read, although I did write a textbook of geriatric medicine several years ago and I would be happy to have it included. But I think we can talk about this a little bit when we get to the manpower issues because there's a bunch of stuff about manpower and specialty versus primary care and GME and what have you. Maybe that would be a time when you and I could share our perspectives on this.

I think the two points I had for you guys were I think there's a palliative care DRG kind of demo in Medicare now. There has been for about a year-and-a-half. And I think this section would be a good section to summarize the experience for that.

MR. COSGROVE: I took actually a quick cut at that data last week. It was used at all about 4,500 times. That DRG would fall or the ICD-9 for palliative care that falls into a catch-all DRG of all other something other services. And that didn't fall into a DRG for payment very often.

So we have like an initial of that. And we will be looking at it further. Out of the 4,500 diagnoses it was the primary just once. It was mostly tertiary to number 10.

DR. ROWE: Right. It's almost never the primary diagnosis. Most of the time what happens is somewhere along the hospitalization people see that care is futile and the family and the patient and the providers make the transition from trying to cure the patient to a palliative mode. So it's not unusual that it wouldn't be the primary diagnosis. People are dying of something, breast cancer or whatever.

But whatever that experience is, I think this might be a good chapter to have it summarized in since HCFA did go ahead with that experiment.

The second thing is I think that as you're going to describe who uses hospice you should describe who uses advance directives, because I think there is the same concern that the African-Americans very infrequently use advance directives. There are these cultural barriers that we don't understand.

MR. COSGROVE: Issues of trust of providers, things of that nature.

MR. MacBAIN: One other aspect on the barrier question, and that is whether Medicare payment policies or other policies regarding hospice programs is a barrier to entry into the marketplace of additional programs.

DR. MYERS: I want to come back to the end of Jack's statement. I think there are a lot of issues surrounding race, there are a lot of issues surrounding socioeconomic status and religion with respect to hospice referral, identification and referral of patients, and the access in certain areas of the country that I think

really need to be looked at in more depth in the outline, that you did acknowledge them verbally but the outline seems to suggest.

I think those are increasingly difficult and problematic issues and will be highlighted over the next several years as the hospice --

MR. COSGROVE: Use of that specifically with hospice referral? I just want to make sure that I have exactly what you said.

DR. MYERS: It's not only referral. It's also the willingness -- the cultural barriers in actually accepting referral as well as making the decision to refer. It's both. They're different and I think they both deserve a look because I clearly think that the numbers that I've heard that need to be explained as to why in certain communities it's very rarely offered and/or used.

I would agree with Gail, I wouldn't spend too much time on the curriculum issue. There are a lot of curriculum experts that --

DR. WILENSKY: Many of them here among us.

[Laughter.]

DR. ROWE: Touche.

DR. MYERS: The last thing I would mention, what is a six month terminal illness? How good are we at identifying what a six month terminal illness is?

MR. COSGROVE: I guess, they say that the model is cancer, which is a little more predictable than some other things, but not perfectly.

DR. CURRERI: But does it really matter? Because it seems to me, when I read this appendix, they have to say the patient is going to die in six months, but once six months is over you can go another 60 days, another 60 days.

DR. WILENSKY: It matters is you're worrying about the IG.

MR. COSGROVE: Right, Operation Restore Trust and red flags, et cetera.

DR. NEWHOUSE: I was just going to agree with Gail on the education side. Since you were asking for areas to emphasize relatively, when I got there, my comment was should come from the profession. There well may be issues about how well the profession is doing it, but I don't think we're the right group to intervene. There are other groups that could do that.

DR. KEMPER: That doesn't prevent us from saying, some attention needs to be directed to it.

I just wanted to come to the number II, assessing the quality of palliative care. I wonder if that shouldn't be broadened to include assessing the quality of care at the end of life, because it seems to me there's a question about quality of palliative care but the real question seems to me the choice between palliative and vigorous, acute interventions. It seems to me some attention ought to be given to the broadening, just from what kind of care do they get once that choice is made.

DR. SHAPIRO: I think that's an excellent point.

DR. NEWHOUSE: As I understand it, one of the issues here is the criteria for being hospitalized. That is to say, if one wanted palliative care and can't for some reason be readily managed at home, there is an issue about whether -- and hospitalization would be clinically indicated -- whether the person is eligible for Medicare benefits because Medicare is supposed to be treating the patient. Is that correct?

DR. ROWE: Medicare is supposed to be providing care.

DR. NEWHOUSE: Care, but active care.

DR. ROWE: I can assure you, Joe, if you were dying with severe pain and I gave you some morphine, you would think that I was actively caring for you. Just because I wasn't making your disease going away, doesn't mean you're not actively caring for them.

DR. NEWHOUSE: I understand. But the issue is, as I understood it from talking with people -- at least in some areas -- there was issue about whether the patient was eligible for Medicare inpatient benefits if they were just being hospitalized for palliative care.

DR. ROWE: I think that was the idea of this palliative care DRG.

MR. COSGROVE: It was my sense that palliative care -- well, I think at this point it's an ICD-9, palliative care, the DRG is. But that was just a way for, I think, the hospital to be able to receive some payment for something. Because as we saw, or as the claims files show, that that is usually a tertiary type of diagnosis, meaning that there's probably something else that has caused -- well, there's something that's caused the dying and the death. And it's my not educated but guess that probably all that can be done in a curative sense has been done, and it's obvious the patient's going to die and the hospital can have a little continuity of care maybe to keep the patient there, in the bed, a little longer time instead of somewhere else. And the hospital can receive a little more reimbursement for that patient.

DR. NEWHOUSE: Let me put it more -- Gail and I are both under the impression that, at least in some areas of the country, hospitals are behaving as if they're not entitled to reimbursement for this kind of patient you just described.

DR. WILENSKY: That is my understanding. It's an either/or.

DR. CURRERI: That's not what it says on page 8 of the appendix.

DR. WILENSKY: I know that's not what it says, but it's at least my impression, that it's an either/or.

DR. NEWHOUSE: That's one reason I'm raising it. To the degree this is the case, and maybe we could establish that or seek to establish it, that this seems to be an issue that we might want to weigh in on.

DR. ROWE: I think that may be happening, if I understand this, is that hospitals have always sort of put down the diagnosis as like cancer, breast cancer say, as opposed to palliative care or uncontrollable pain or breathlessness, or whatever the real reason to be admitted is. And they get paid for under that. And many of them are now saying well, that's a ruse and we're not going to do it anymore. We want HCFA to stand up and recognize that palliative care is an appropriate and compensatable kind of care.

DR. NEWHOUSE: That's part of it. But I'm also hearing anecdotes about patients being bounced out of the hospital but UR committees on this ground, or PROs even sometimes.

DR. ROWE: I understand now. I completely missed that, that hospitals are not accepting patients who require this care because they say that HCFA isn't going to reimburse them?

DR. NEWHOUSE: Or the intermediary isn't going to reimburse them.

DR. CURRERI: I think one of the problems is that there is a cap of $15,000. So even though you can be hospitalized --

DR. NEWHOUSE: No, I'm not talking about hospice. I'm talking about traditional Medicare.

DR. CURRERI: Then I didn't follow your point. Maybe you could state it again.

DR. NEWHOUSE: The issue is what are the criteria under which a patient is eligible for hospital reimbursement in the traditional Medicare program? My understanding was that the patient is supposed to benefit therapeutically from being in the hospital. But that's being intepreted as the patient's supposed to be under active treatment for some disease.

DR. ROWE: That's really crazy.

DR. NEWHOUSE: I agree. But the issue is, is that the case? And are people, in fact, interpreting the statute in that fashion?

DR. WILENSKY: Obviously when we get to having some additional work, this is an area that we just would like to get some clarification and also be clear.

MR. COSGROVE: I've actually heard sort of the other way, that in other care facilities, not to the level of a hospital, there's admittance to the hospital say when people in a nursing home. I know this, I think, happens more in the Medicare programs, that patients will be transferred from a nursing home. The staff there isn't as equipped to deal with the final stage of an illness, and some of the acute, emerging conditions in that stage. So I've heard actually just the opposite, so this definitely looks like something to look into.

MR. GUTERMAN: I think in general the hospitals are concerned because cases are reviewed and denied occasionally, and hospitals are concerned in general that they can justify that the care has to be provided in a hospital. It's not whether the care is justified but whether the location of the care is justified. Remember that the palliative care code is a new one. I think HCFA is looking at this more than from the payment perspective, because there are some difficult situations raised by the use of -- by extra payment for palliative care in the hospital, other things being equal.

They're looking more as making information available about what kind of care is provided where, than as a potential payment policy.

But as with many other payment policies, where providers are worried about being reviewed and denied payment. Hospitals in different parts of the country or different types of hospitals may have different takes on the risk that they're bearing when they decide to provide care in one setting or another. So they may be responding differently in different parts of the country.

DR. WILENSKY: Any further comments?

DR. SHAPIRO: Can I just clarify before we break on what work, if any, is left on the professional education section? I had envisioned that section not to contain recommendations because of the particular policy area that it's in. But I thought that it was worth including for completeness because one of the factors preventing good quality care from being delivered, I think, is that some providers are not sufficiently knowledgeable or skilled in the content of care required.

This section was intended to just document the extent to which the profession is responding to that deficiency. I don't envision that it would necessarily be a bad news section. There are a lot of educational initiatives that have been begun to try to correct this problem. So it's kind of more a descriptive documentation section, rather than something that's intended to produce recommendations.

So the question is are you still interested in having something like that in the chapter, or should we just not consider it at all?

DR. WILENSKY: I don't have any objection to raising that this is an issue. I just would, in terms of the workplan, much rather see you focus on the issues say that Woody raised. If we were going to go out and actually do a survey, I'd much rather see a survey why it is that people of color do not appear to have recommendations or use hospice or advance directives. Whether it's the providers they see or something about the community beliefs itself.

I just would personally rather see that kind of a survey than a survey of curricula because I don't know, Jack as an exception, that most of us would be in a position to have useful comments on curricula and textbook and training programs, although I agree with Joe's comment that saying that this is an area that we think that the professions or the accrediting groups for medical school residency ought to take a more proactive position than they have to date, that it is an area that needs to be emphasized or augmented, both because of the

aging of the population and because of the change in technology which are allowing people to live longer, so that you basically make a comment but without having workplan time.

It really was the workplan emphasis that concerned me, relative to some of the other issues that we've raised. Or this question that we've just gotten into now also strikes me as something more that we may be able to say something and use our own expertise. Is there a problem with hospitals being able to hospitalize individuals with a non-specific acute illnesses because of pain management or other issues that are related to the care at the end of life. That also strikes me as something where we're much more likely, with the expertise around the table and the expertise on the staff, to be able to make useful contributions.

Making the statement that this is an area in which the professions need to be sure that new physicians and nurses and other care providers have appropriate training and appropriate curricula is important. That was the intent of my comment.

DR. KEMPER: What you wrote sounded much more ambitious than what you just said.

DR. WILENSKY: It did to me, as well. It was the workplan that made me go whoa.

DR. SHAPIRO: That's very helpful direction because now we won't do any of the workplan ideas and we'll take it as a given that this has been a neglected area in professional area, describe some of the efforts that are underway to correct that, and say that this is an important part of the solution.

DR. WILENSKY: And to the extent that respond --

DR. ROWE: It wouldn't be bad to plug my book.

[Laughter.]

DR. WILENSKY: Thank you. We have covered a variety of topics this morning and before we go to the section on end-stage renal disease, let me open this up for comments to the public.

MS. McELRATH: I just want to go back to the discussion this morning on the physician payment rule. One thing that the rule didn't say and that makes this of more immediate importance than it might have seemed on the SGR

is that HCFA also had projected in 1998 that the GDP would be 1.1 percent. It was actually 2.5 percent. They also overestimated the number of people that would remain in fee-for-service. So there's some offset, but overall the SGR was probably about 1 percent too low. That means that the payments, the updates, in 1999 will also be too low.

HCFA did ask for comments on this rule by December the 2nd, so that if you thought what you wanted to repeat what PPRC had said about the need for an adjustment, that would probably be helpful.

Also, on the question of other things that maybe ought to be adjusted for, not just the age of the patients but the change in the mix of patients as more people go into managed care. And if it's true that more people who are left will be the sicker people, using greater intensity of services, you might want to look at that as another possible adjuster.

DR. WILENSKY: Sharon, we know you from PPRC, but some of the others don't, if you want to identify yourself.

MS. McELRATH: I'm sorry. I'm Sharon McElrath with the AMA.

On the practice expense issue, one question when you get into the data and how would you expand the data, fill in some of the gaps, the question is who's going to pay for that? Some of the specialties have been, some of them, getting oversamples but it's a question if they pay for it how HCFA's going to take that data. Whether the AMA would pay for that, which seems to be sort of where they may be heading, is another question I'm not at all certain that the AMA would want to take that on.

DR. WILENSKY: Actually that's what I assumed the answer was, but I won't raise it.

MS. McELRATH: The budget neutrality adjuster -- I don't know if you want to get into this, but it does matter where you put that adjuster. If you make the adjustment on conversion factor, which is what HCFA has now gone to doing, there are some codes that have only a technical component. So if you are making a work adjustment, and then making a budget neutrality adjustment because all of the work values went up, or some of them went up, the technical component only never got any of the benefit of that work increase, but they will be penalized if you put that adjustment on the conversion factor.

So there is some technical reason to put it one place versus the other. You may want to weigh that against the complexity of how you do it.

MS. COYLE: Carmela Coyle with the American Hospital Association.

Comments on the workplan around care at the end of life, the AHA has been working for the last year-and-a-half to two years around this and would like to offer anything that we've done as a resource.

A couple of things in particular, we publish on an annual basis the Dartmouth Atlas of Health Care, which is Jack Wennberg's work around variations in practice patterns. The upcoming version of the atlas is going to focus on care at the end of life. And to the extent that that would be helpful and provide some useful information and data, we'd be happy to share that with you.

The second is we received a grant from the Robert Wood Johnson Foundation to explore an award around and of life care. Again, to the extent you're looking at the potential promotion of research and education on this issue, again sort of what we've learned in the seed process there may be helpful to you and we'd be happy to share with the Commission and with staff.

DR. WILENSKY: Thank you.

DR. CASEY: I'm Dr. Don Casey. I'm from the Maryland-D.C. PRO and I wanted to get at an issue that Dr. Newhouse raised about issuance of notice of non-coverage. But before I do that, I just wanted

to make a comment to the panelists regarding, as a former hospice director in rural Arizona, just to point out that many of the patients who did not have insurance or were underinsured, including Medicare patients in addition, looked to the hospice as an important way of saving money. So I would perhaps think about that issue of uncompensated care especially in isolated rural communities.

But getting to the issue of notice of non-coverage, it is a valid issue that criteria which PROs use to make these decisions have not really been looked at for quite a long time. I think that in the context of this issue of palliative and end of life care, I think it would be useful. Oftentimes what happens -- someone said well, I've heard it one way and then someone said well, I've heard it the other way. I think the answer is actually it's both ways.

What happens is the patients fall into a situation where they don't fit into either, so there's an easy way of getting out of that. So I would suggest you look at the notice of non-coverage criteria as part of that.

DR. WILENSKY: Thank you. We'll go to the last session for the morning, that's the workplan on end-stage renal disease. Dana, Nancy?

MS. KELLEY: Good morning. Nancy and I are here to discuss with you the staff's workplan on end-stage renal disease.

As you know, the 1972 amendments to the Social Security Act extended Medicare coverage to eligible persons of any age who were diagnosed with ESRD. ESRD beneficiaries are entitled to all Medicare covered services, including specific services to treat ESRD, such as dialysis and kidney transplantation. Benefits generally begin three months after eligibility is established, except for patients with employer-sponsored health insurance. For these patients, Medicare makes secondary payments for the first 30 months of Medicare eligibility.

Just some background on the ESRD program. The number of beneficiaries has risen steadily over the last 10 years, increasing an average of 8.4 percent per year between the years 1986 and 1996. In 1996 there were over 66,000 new Medicare ESRD beneficiaries. Half of these new enrollees were over 65. In total, there were over a quarter million enrollees with ESRD in 1996. About 80 percent of ESRD patients are treated with dialysis and the remainder have a functioning transplant.

Expenditures for these patients have increased more than 13 percent per year since 1986. Overall Medicare spent more than $8.4 billion for ESRD beneficiaries in 1994, about 5 percent of total program expenditures. On average, Medicare spent in excess of $33,000 for each ESRD enrollee in 1994, more than seven times the average for other beneficiaries. This reflects the high cost of transplantation and dialysis, as well as high overall morbidity for these patients.

The workplan for ESRD begins, as always, with the analysis required to support the Commission's March recommendation on an update to the payment rate for dialysis facilities. OBRA 1990 requires MedPAC to make this recommendation.

Using 1997 Medicare cost report data, we're going to analyze the reported costs of furnishing dialysis treatments to determine the adequacy of the current payment rates. We'll also assess productivity indicators, such as the average length of dialysis sessions and the number of treatments per FTE. In addition, we'll compile data on Medicare spending for ESRD patients, out-of-pocket spending, and beneficiaries' use of services. This information will be presented at the January meeting.

At the same time, we plan to step back and take a broader look at the ESRD program in the coming year and beyond. In your reading materials we outlined a number of issues we hoped to explore. The first is anemia. Most people with ESRD are anemic because their kidneys do not produce enough erythropoietin, a protein that stimulates the production of red blood cells.

There is a genetically engineered substitute for this protein called Epogen. That drug alleviates anemia and is taken by most dialysis patients. Medicare does cover the use of Epogen, paying facilities $10 per 1,000 units of the drug administered.

During clinical trials, patient response to Epogen was very positive, but the rise in average hematocrit levels in the patient population has not been as dramatic, even in response to increases in the average dose of the drug. This may be due to poor nutrition in dialysis patients. Iron stores, in particular, may be inadequate.

As the dominant payer for Epogen, Medicare has an interest in ensuring that the drug, which can improve quality of life, be used so as to maximize its effectiveness. To better understand anemia in ESRD patients and its treatment, we plan to review the literature on control of anemia, and then to assess Medicare's payment policies for Epogen, intravenous iron therapy, and other therapies and services that may improve the effectiveness of Epogen. This will allow the Commission to consider whether changes in payment policy for Epogen or for other therapies and services are necessary. We plan to present this information sometime in the spring for the June report.

Also planned for the June report is an analysis of dialysis adequacy. A number of factors contribute to the adequacy of dialysis, including the body mass of the patient, the length of the dialysis session, and the intensity of the dialysis. Over time, the frequency of dialysis is also an important factor.

Adequacy of dialysis has important consequences for patient health and quality of life. It also affects Medicare spending, since patients who receive adequate doses of dialysis have fewer complications and comorbidities. Recently, the Medicare claim form for dialysis services was changed to include a measure of dialysis adequacy, the urea reduction ratio, or URR. The ESRD networks also collect information on

adequacy for a sample of patients. But there is some concern that providers can manipulate these measures of adequacy to their advantage.

In addition, it's not clear that current Medicare payment policies allow for the provision of optimal dialysis, for example for daily dialysis.

We plan to review the literature to determine what is considered to be an adequate amount of dialysis, how the amount of dialysis delivered can be improved, and factors that might inhibit the delivery of optimal dialysis. We will assess the contribution of payment incentives, and also analyze the most frequently used measures of adequacy and their reliability and assess the extent to which such indicators could be tied to payment. As data become available, we'll use the claims to track adequacy in Medicare patients.

Related to these issues is the more global question of how Medicare pays for all the care furnished to ESRD patients. As you know, Medicare's payment for dialysis providers for outpatient dialysis services, called the composite payment, is a bundled payment for the supplies, drugs, tests and services that are routinely supplied during a dialysis treatment. Physicians are generally paid a monthly capitation payment, although they can bill separately for outpatient surgical services and for inpatient services, including those related to inpatient dialysis. These bundled payments are intended to promote efficiency in care.

But as with all bundled payments, the incentive exists for providers to stint on care. The potential for stinting may be especially great under the current payment system because providers bear no financial responsibility of poor maintenance care results in hospitalization.

If payment were set appropriately, expanding the bundle to include all services furnished to ESRD patients might enhance both efficiency and quality of care. HCFA is currently sponsoring a three year demonstration project to assess whether ESRD beneficiaries should be enrolled in Medicare managed care plans. Plans began enrolling beneficiaries in 1997 and we've been monitoring the progress of the

demonstration and are awaiting answers to a couple of questions, such as how the dialysis dose and other clinical factors differ when providers are held responsible for all the care a patient receives.

We'll also be interested to see of transplant rates differ from those in patients under fee-for service. We're also planning to conduct some analyses of our own on this issue. We hope to document the relationship between length, frequency and adequacy of dialysis and hospitalization rates. We also want to examine hospitalization rates for ESRD patients separately. These appear to be rising. Physician payment for common inpatient services furnished to ESRD patients will also be analyzed.

All this information will help you evaluate the adequacy of the current payment system for ESRD services.

I'll just talk about one other area that we've thought about, and that is transplantation. Medicare covers the costs associated with the transplant, including organ procurement costs and the full cost of care for the kidney donor, if necessary. The program also cares for post-transplant immunosuppressive drugs for up to three years.

There are a number of important issues related to transplantation that the staff plans to explore, including access to transplant services, differences in access across racial and ethnic groups, the distribution of grafts, and long-term coverage of immunosuppressive drugs.

That's a summary of the work we've planned and I'm sure you'll let us know if we've missed any important issues. Nancy and I will be happy to answer any questions you have.

DR. WILENSKY: Any questions? Woody?

DR. MYERS: The graph you presented with respect to Medicare ESRD program incidence, that's just Medicare patients coming into the program, it doesn't represent the true incidence of end-stage renal disease. It would be very interesting to know, and perhaps some of my colleagues already know, how this

doubling in six years is related to the true incidence and how much of this is a public health emergency from untreated hypertension versus how much of it is providers now willing to admit that their patients could benefit from the Medicare program, encouraging enrollment, and the data being collected better or other factors. I think it's important to know why that doubling has occurred with respect to Medicare.

I would also encourage you to look at the quality of care issue with respect to the erythropoietin, emergence of what I think is becoming a good marker for quality of care in end-stage renal disease; i.e., those patients that are not on it, why aren't they on it if they have demonstrated anemia, and that the program payments are, in various geographic areas, in various facilities, or for various types of patients or groups of patients. It would be an interesting quality of care marker as well, along with what you're trying to assess with respect to transplantation which is, I think, of increasing concern amongst many of my colleagues as to why such differentials continue to exist in the late 1990s for transplantation referral. And what is it that the program ought to be doing about that?

So you've got some really good issues here from both a quality of care and cost perspective, and I would encourage you to perhaps augment your analysis with those few comments.

DR. NEWHOUSE: I was thinking along the same lines Woody was, and even a little more broadly. In looking at your chart on dollars, the dollars from '86 to '96 roughly tripled, and the number of beneficiaries roughly doubled. This was at a time when the composite rate was essentially constant.

In addition, I'm trying to understand why the number of beneficiaries have doubled. I'd like to know why the payments have tripled. That might point then toward areas where we'd like to comment.

Then I have an issue that's a little similar to Ted and professional liability. I'd like you to humor me and not call this adjustment the productivity adjustment, since the productivity adjustment applies

I've got the same product or if I've adjusted for differences in the product. So call it the through-put adjustment or something else, not productivity.

DR. CURRERI: You made the comment both in the text and in your oral presentation that providers can easily manipulate the test for adequacy in dialysis. I was trying to figure out how they can do that. One is measuring specific laboratory results that can be easily audited. So can you tell me how they are doing it?

MS. KELLEY: Actually I've only heard that. I've not researched it myself. I wonder if our esteemed physician, Dr. Lewers, could give us a brief summary of whether this is indeed possible.

DR. LEWERS: Quite frankly, that's fraud. If that's occurring, then we would like to know about it if you can just let us know where it's occurred.

It is very difficult to manipulate it. There are various ways of determining it, but that's pretty well set on how you determine the URRs and the KVs over T now. So I think manipulation of that data would be pretty difficult to do without true fraud and without manipulation for the purpose of gaining reimbursement.

MS. KELLEY: This is something that we've only heard anecdotally from others. It's not anything that we have any proof is occurring.

DR. CURRERI: My point is, I don't really think we should put that in unless we know it's happening.

DR. LEWERS: That was the point I was going to make at a later point.

MS. KELLEY: Absolutely. What's here is not necessarily what's going to end up in the Commission's report, absolutely.

DR. LEWERS: The point that Woody was making on the incidence and, quite frankly, that's the failure of our system, is the failure to treat hypertension and the failure to adequately treat diabetes. I think

we need to address that and make some comments on it. That growth doesn't represent the disease that's growing, it purely is that we are failing to treat it.

There are a lot of reasons for that, the availability of medications being one, some of the restrictions on referral, but the new program for diabetes should be very effective if we can get that off and running.

One of the other reasons, Joe, I think that money has increased over was that initially was the payment for Epo, as you know, it was outside of the composite rate. So I think some of that probably is related but it doesn't explain it all.

I know you're not going to put all the stuff that's in this chapter or what we have here before us, but I think you also have to understand that where we talk about the hematocrit, the anemia and treatment of anemia, you come into a couple of factors and you comment about even though we increased supposedly availability and got rid of the cap on the hematocrit.

If you're not familiar with it, when they put Epo out, you could only take the hematocrit up to 36. When it got to 36, you had to stop giving the drug. And if you gave the drug when it was over 36, what happens is it immediately drops back down. So you're doing this sort of thing because of a payment. That's been changed.

But you've got to look at the data of your data because that's only been a couple of years. So I'm not sure of the date of your data, but there are other factors involved. You point out some of these. I think when you do that you need to take a look at the others.

For instance, this population has complications of everything, and a lot of inflammatory disease. Surgical procedure will reduce your hematocrit because of the inflammation that occurs. We don't use aluminum binders anymore, but aluminum levels will do that.

Also, at the same time that you increase the availability of Epo, then we had a problem with the intravenous iron and giving intravenous stores and they were not available. So there are a lot of factors which have contributed to that, not just the erythropoietin level.

The other element that's very important in intensity of dialysis is the equipment that's used, what is available. Not only the length of dialysis but what kidney are you using and the various coefficient factors that are related to that.

The other thing is that I get the impression here, in many areas, where we talk about stinting on care, which is something I don't like to see, stint on care. Again that, where it's for incentives to gain money, is fraud and should not ever occur. But the other thing is quality care is cost effective care. Quite frankly, if you're going to stint on care, and every nephrologist knows that if you're going to do that, then the mortality and the morbidity goes up. Quite frankly, if you're saying that you're doing that in order to gain money, well you lose money because you don't get paid for dead patients.

So quality care is cost effective care. The best quality you can provide to keep the people alive longer, if it purely is an incentive to gain money, then that's certainly not the way to go. I think everybody knows that.

So I had a problem in what I read here, not in the other information you gave me earlier, that indication that we're holding back on care for financial reasons when I think quite the reverse is the case.

On transplants, one of the major problems is the donor programs. I think we should spend some time talking about donor availability and emphasis on donor programs and how we can get people to become donors and sign up for that, because that's an area that that probably is the major problem. These other issues are minor issues.

The only other question which I had, you've left out the fact that you've got to be eligible for Social Security benefits. That's why a lot of people are not in the program. If you're not eligible for Social Security benefits, then you're not eligible for the program. So that's an area I think needs to be emphasized.

When you talk about types of persons, I'm not sure that that's quite what you're talking about. That's not the reason, it's not the type of person that's involved. It's these other issues, as to where you talk about the entitlement program you talk about types of persons. I wasn't sure what you meant by type of person.

MS. KELLEY: Just if people of certain race or ethnic groups or socioeconomic status were more likely to not be covered and therefore, where do they get their coverage? Many of them are covered by Medicaid, for example.

DR. LEWERS: Right. Gail, if I might, in the past here I have told this group, and they follow us and know what we do, I have professed my conflict of interest. I want you to know that's now been removed. I have discontinued my association with what's listed in my conflict of interest and I can pretty well say what I want.

DR. WILENSKY: Thanks for that clarification.

MS. NEWPORT: Just a couple of minor technical questions. I'm sorry, I haven't memorized all of BBA, but wasn't there a change of coverage in BBA for managed care? Or have I misremembered?

MS. KELLEY: Yes. For managed care?

MS. NEWPORT: Yes. Right now in managed care, or it used to be, if someone presented who was ESRD eligible, we were not allowed to enroll them.

MS. KELLEY: Not unless they had already been enrolled, right.

MS. NEWPORT: Was that changed, or am I hallucinating? I must be hallucinating.

MS. KELLEY: There is a demonstration.

MS. NEWPORT: How many demonstrations are there?

MS. KELLEY: There were four sites and one dropped out.

VOICE: It's one demo, three sites.

MS. NEWPORT: When are the demos supposed to have their results in or studied or evaluated or presented?

MS. KELLEY: I believe the demo ends in 2001; is that right?

VOICE: The demo started enrolling the different sites differently and they're enrolled for three years.

MS. NEWPORT: That's really what I was looking at, is what the results would be.

MS. KELLEY: And then there will be an evaluation.

MR. MacBAIN: As I recall, and maybe some of my former ProPAC colleagues can help me on this, didn't we have a panel of experts on dialysis about two years ago?

That, I think, was the source of Dana's comment on the ability to manipulate a measure. As I recall, it was one of the panelists suggested that when you drew the specimen could have an impact on what the subsequent measure was. I don't think it was the URR and I don't remember just what --

MS. KELLEY: The KV over T.

MR. MacBAIN: But speaking of that panel, if somewhere in the dusty archives of ProPAC there is a summary or transcript of that panel, I don't think it would help us to repeat it right now but it would be good to distribute that. I would be interested in refresh my mind on what they said, because as I recall it helped to clarify a lot of the surrounding issues from the perspective of the industry.

Also, and this is something that came up in that panel and I've run into it subsequently. You mention in the paper that now hemodialysis is the most common modality in the United States. I believe in other countries there's a much higher frequency of use of peritoneal dialysis. Also you mention the limits on frequency that seem to be imposed by the payment system, and one of our panelists suggested that daily dialysis was producing better results in a lot of ways collateral to just the immediate physical functioning.

It would be helpful in looking at benchmarks and comparative literature to take a look at what's going on in other countries as well, recognizing that probably has to be adjusted for admission criteria: that some countries get better results because they admit healthier patients to begin with. But I think it would really be useful to get more of an international perspective on this.

MS. KELLEY: Okay.

DR. ROWE: I had two comments. One is about pancreas transplants. As you know, diabetes is an important subset of the patients on end stage renal disease and current treatment is often a renal transplant at the same time as a pancreas transplant. I don't know if that's covered by Medicare and it's included in these expenditures, or whether that's an emerging technology that we might comment on or whatever. Do you know, Ted?

DR. LEWERS: You mean the payment?

DR. ROWE: Yes.

DR. LEWERS: I think it is. I'd have to look at it but I'm pretty sure it is.

DR. ROWE: It may be part of the increase that Joe was looking at, that the tripling of cost. I thought of Epo, as you did. But I think pancreas transplant might be another one of those pieces where it's still one patient but it's two transplants.

DR. NEWHOUSE: Also Stuart noted it's all services, not just ESRD, that's on the graph.

MS. KELLEY: Right.

DR. ROWE: Okay. Then there was another point. We had a discussion a few minutes ago about developing some training of doctors, curriculum, and all that. We'll maybe get to it some more tomorrow. But there was a statement that you made in your presentation, Dana, that's also in this and I think it's relevant to it. When you hear it, rather than think of Epo, think of palliative care.

It says, as the dominant payer for Epo, Medicare has an interest in ensuring that the drug is used so as to maximize its effectiveness. I think if we're the dominant payer in something and we accept that we have a responsibility for maximizing effectiveness, whatever that is, whether it's Epo or client care, then that's our responsibility. So I particularly liked that.

MS. KELLEY: Thank you.

DR. WILENSKY: Amazing how much power you can have as a staff person.

[Laughter.]

DR. LEWERS: Can I just comment on a couple things Bill said?

DR. WILENSKY: Yes, Ted. Go ahead.

DR. LEWERS: The point that Bill was making about daily dialysis certainly is effective. There is now a new procedure which is coming along and being developed and it was presented to us, I believe it was last year we got some mailings on it. That's coming along and looks pretty good and it certainly does improve. The KV over T that you're talking about, timing is important. But you can do the same thing with the URR which is the adjustment.

And peritoneal dialysis has grown in this country. There are some recent studies and there is an evaluation undergoing currently that there appears to be a higher mortality rate in the patients who are on

peritoneal dialysis. So in some areas you've seen a slowing or a drop back in the numbers until that's available. It's not clear why that occurs at this point in time.

The other point which I guess I should make, Dana, is the fact we made the last time is HCFA is collecting all that data on the URRs when they come in on each claim form. I didn't know what they were going to do with it last year. I don't know what they're going to do with it this year. So I think it's a pure duplication of effort that's going on within the network system which is already there. So if you can find that out -- I mean, we tried to find out, if you remember, last year and didn't.

MS. KELLEY: The difference is that the URR, the claims -- HCFA is now collecting the URR for every patient as opposed to the networks which collect it for a sample of patients. As to exactly what HCFA is planning on doing with the data, I'm not sure at this time.

DR. LEWERS: We'll ask the same question next year.

MS. RAY: There is the potential with the URR data being collected on the patient level basis to be able to do patient level analyses with respect to outcome. That right now the data is still coming in, but perhaps after another six months or so those types of studies may be initiated.

DR. WILENSKY: Any other comment?

Anyone from the public that would like to make public comments? There's also, I know, some people from HCFA here if they want to respond to the HCFA issue.

MR. GREER: Joel Greer from HCFA. Let me try and answer one or two of the factual questions. I am an economist, not a physician. My understanding of the medical issue is that both URR and KT over V, two alternative but related measures of adequacy of dialysis, are both measured by drawing blood and measuring BUNs, which is a certain lab test, before and after a dialysis session.

The timing of the draw after transplantation is very critical to the outcome. So it's fairly easy to make some significant changes in your results by adjusting the timing and the settings of the dialysis machine when you draw the blood, whether you turn the machine off, have it run slowly, et cetera.

The blood draw, as with any lab test, has a fairly large amount of variance in it anyway. So you can add gaming, if you want to call it that, to legitimate mismeasurement. I don't want to stress the mismeasurement. You know, it averages out.

Was there any other comment or any other question that I might be able to address?

DR. NEWHOUSE: What HCFA is going to do with the data.

MR. GREER: First of all, I think the data are currently being collected. They've been collected less than a year, because we started January 1st of 1998. We've looked at how many bills are being sent in that include the data, and as of the early summer most of the bills we were getting had a value that was not totally unreasonable. So we have been looking at the data. Exactly how it will be used, I do not know, and even if I did I could not speak for HCFA.

But a major issue from HCFA's point of view is exactly what Dana said, getting it for all patients, not just a sample. This would both allow us to get a better indicator for all patients and do better analyses. It would also allow us to look at individual regions and possibly even individual providers. As a statistician, which is one of the hats I sometimes wear within HCFA, I would say this is most unlikely to be methodologically rigorous, but it is something that we would like to be able to do if we thought we could.

DR. LEWERS: Would you plan to utilize that data with the networks in that data as far as an educational tool if there are problems, since the networks are collecting similar data, although I agree a sample is different.

MR. GREER: Absolutely yes to sharing with networks whatever we have done. We've been sharing Epo data with networks for quite a while and networks have been working with individual providers and with their regions and states as a whole for many years on improving anemia treatment.

Medicare payment for pancreas treatment was a question raised. For pancreas treatment, since diabetes is the single most important cause of the kidney failing, this is an important issue. HCFA has not reimbursed for a sole pancreas transplant and still does not. There is no DRG for it, for example.

When a pancreas and kidney are transplanted simultaneously, the payment is the average of all kidney transplant costs, which is how we set a DRG payment, in very gross layman's terms. So that would include some transplants that include a pancreas treatment. But we do not distinguish in a given reimbursement whether there was also a pancreas transplanted at the same time as the kidney.

So the answer is, no, we don't pay for a pancreas treatment or a pancreas transplant, but actually the payment rate might be higher than it would otherwise be because some kidney transplants include a pancreas.

DR. ROWE: Do we know what proportion of all renal transplants are renal plus pancreas? It's probably a very small --

MR. GREER: It's very small. It would absolutely have to be about 10 -- it could not be much more than 10 percent. But that's a very back-of-the-envelope.

DR. LEWERS: I've never had a patient have a kidney-pancreas and I've done a lot of those. I've never had a patient complain or seen anybody dunned for the money. So they must be paying adequately if nobody has complained.

DR. ROWE: Everybody should be aware, they both come from the same donor obviously.

DR. LEWERS: Right, at the same time.

DR. ROWE: Right, at the same time. There's not a procurement problem. If you get the kidney, you get the pancreas.

DR. WILENSKY: Fred?

MR. GRAEFE: Thank you, Gail. Fred Graefe. I'm merely a Washington lawyer, neither a physician or an economist, with Baker & Hostetler representing Baxter Renal Management Services. I just wanted to state that we think that the Commission's workplan is on the right track.

Secondly, to allow the Commission to see a similar, related statement that Dr. Allen Hall, on behalf of Baxter, testified to the Medicare Commission in September on the issue that Ms. Newport raised on removing the bar of Section 18.76 and some related issues.

Thank you.

MS. KELLEY: I have a copy of that and I'll distribute it.

MS. GAMPEL: Gwen Gampel, Congressional Consultants, representing the National Renal Administrators Association. I'd like to first thank Dr. Lewers for correcting several of the statements of the staff.

But Dana's statement basically was the patient population has doubled but the expenditures have tripled. I think you need to understand that that $8.4 billion, about one-third of it is paid to the physicians under both outpatient and inpatient payments, about one-third is paid to dialysis facilities, and 40 percent of it is paid to the hospitals.

Your comment that whether facilities are withholding care, I think Dr. Lewers was right, you don't get paid for a dead patient. You also don't get paid for a patient that is hospitalized. So really the dialysis facility has every incentive in this payment to make sure that their patient is properly cared for in that dialysis

facility because if they're not, they're hospitalized and they lose all those payments for the treatments while that patient is in the hospital.

But bigger than that is when you look back at these patient populations, as Dana pointed out, the majority of patients now are over 65 that enter this program. They enter because they have hypertension, they have diabetes; 70 percent of this population has heart disease. So when you look at that hospitalization, is that hospitalization, that 40 percent of that $8.4 billion, is it related to the dialysis care? Is it that the facility isn't providing adequate care and therefore the patient is hospitalized? Or is that patient hospitalized because of their heart condition, because of their diabetes, because of their hypertension, because of all of their other comorbid conditions?

I think that's very important to look at those things because frequently the dialysis facility is blamed for the fact that that patient is in the hospital when it has absolutely nothing to do with their dialysis treatment.

So I would urge the Commission to look at, why are those patients hospitalized? Is it related to their ESRD condition? And really when you look at those total dollars, really that $8.4 billion, some of those dollars really have nothing to do with ESRD. So when you look at whether it's doubling of the patient population but tripling of the costs, are those costs really ESRD related, or are they related to a hospitalization that has absolutely nothing to do with the fact that that patient has kidney failure?

I think when you look at it in that perspective you're going to see a very different kind of statistics than you see when you just look at doubling and tripling of patient population and expenses. So I hope that you will focus on those issues when you look at a composite rate increases.

Those are my comments.

DR. ROWE: Gail, relevant to that comment, could we ask the staff to give us some data on the relative changes in the payment to the hospital, to the dialysis facilities, and to the physicians?

DR. WILENSKY: My understanding is what we've asked the staff to do is precisely what Gwen was saying, is to give us information that will explain the rise so that we can understand which factors led to it, and to the extent that they're related to each other, what that relationship is.

MR. CHINCHANO: I'm Dolph Chinchano of the National Kidney Foundation and I wanted to bring your attention to a project of the National Kidney Foundation and our sister organizations which is known as the dialysis outcomes quality initiative. As part of that, what we call DOQI, the National Kidney Foundation has issued four evidence-based practice guidelines which may be useful in your deliberations. They relate to adequacy of hemodialysis, adequacy of peritoneal dialysis, management of anemia in dialysis patients, and lastly, vascular access placement and maintenance.

Parenthetically, vascular access is an issue that you might want to consider because vascular access complications are one of the largest causes of hospitalizations, and those hospitalizations are a major component of the increase in ESRD expenditures.

These practice guidelines address many of the issues that were raised here this morning, including how do you make sure that KT over V measurements are comparable from unit to unit and patient to patient, how to achieve optimum anemia therapy with erythropoietin. So I once again draw them to your attention.

Finally, there is a fifth practice guideline in the area of nutrition which is under development and will be available in April. I have provided the first four guidelines to Dana and will be glad to give you the fifth as soon as it's available.

Thank you.

DR. WILENSKY: Thank you.

DR. CASEY: Don Casey again from the Maryland-D.C. PRO. Just to add on to your statement. I just wanted to make one quick comment to Dr. Myers question about the incidence, and that is to consider the quality of the available technology as being a factor.

But let me just speak as a physician involved with quality improvement at the PRO level for ESRD. We have translated those DOQI indicators, DOQI guidelines, if you will, into indicators with the collaboration of the networks that Dr. Lewers spoke about and are, as we speak, collecting specific information about adequacy in a very comprehensive fashion that looks at a lot of these issues. I know that other PROs are involved with other networks as well.

I think that given the fact that long about '93 or '94 when we had a much better way of measuring adequacy than we did in the past -- granted there are flaws with that -- I think that the evolving evidence that we generate will be very useful to the Commission.

I also would just remind you that the evolving medical evidence indicates that more is better, and that the use of Epo seems to be inversely proportional -- seems to be -- to the adequacy of dialysis as well. So those are a couple things to consider. But certainly I might expect the costs, the needs to increase if more patients are going to be dialyzed more often.

MR. AHOE: My name is David Ahoe. I am with a company called Health Care Alliance in Lake Forest, Illinois. But I represent a small startup dialysis company by the name of Access. I compliment the commissioners' request to look back at that September 1997 ProPAC meeting. There was an awful lot of excellent information put together that a number of people contributed to.

The second point that was also raised is the international data. We have done extensive international data that we will share with the Commission on payment policies throughout the world, where

we're trying to determine the best place to introduce this new technology. Just one quick example of Japan where one is paid X yen for providing three times per week and almost double X yen for reaching that plateau of the fourth or fifth treatment per week. So there really are incentives to get people to that next level; i.e., requiring more dialysis time, and we'll share with the Commission.

Thank you for your study of this issue.

DR. WILENSKY: Thank you. We are now going to go into recess until 1:30 when we will reconvene.

[Whereupon, at 12:36 p.m., the meeting was recessed, to reconvene at 1:43 p.m., this same day.]

AFTERNOON SESSION [1:43 p.m.]

DR. WILENSKY: Judy and Dan, financial liability.

MS. XANTHOPOULOS: As Dan and I started to investigate the issue of beneficiary financial liability we felt that we must be aware of Medicare's goals or what the motivation is of the system before we embark on this approach. So it's a clearly a question of whether it is primarily to decrease the financial liability of beneficiaries or the focus being access, quality of care, quality of life issues.

We felt that basically looking at past research and looking at the information available at this point that depending upon your perspective, your starting point, you might come to very different conclusions about how efficient or how well Medicare is serving its mission, its purpose.

So we stepped back a little bit and tried to identify several questions that we wanted to answer in our analysis. Dan will talk about the first two, which are what has previous research taught us? Trying to look at the previous studies and see where we think we might be able to improve upon that work. His other area is, what are the primary issues that he'll want to address in his work.

I'm going to talk about alternative methods of analysis, which include data enhancement, and trying to elaborate on the current data sources that we have, to make them a little bit richer of information. Then we're going to discuss our future modeling plans which will hopefully enable us to address a lot of the policy issues in an aggregate fashion.

MR. ZABINSKI: Today I'm going to talk about recent financial liability studies, how we think we can improve upon those studies, and implementing those improvements for our study for the June report.

Recent financial liability studies primarily have focused on out-of-pocket spending, and the studies used two general methods to present financial liability. One is just to show mean out-of-pocket spending by beneficiary characteristics such as insurance status and income to poverty ratio or to show mean spending within components of total spending, components such as supplemental insurance and prescription drugs.

The other method used to present financial liability is to show the ratio of family out-of-pocket spending relative to family income by beneficiary characteristics, once again such as income-to-poverty ratio.

This first diagram I have here is a very common way that's been used to present mean out-of-pocket spending. What we did here is we used data from the 1995 Medicare current beneficiary survey and drew a sample out of the MCBS that consists of beneficiaries who spent no time in institutions such as nursing homes during the survey, and who also survived the entire year of the analysis. We call that population that living non-institutionalized.

Along the horizontal access -- sorry you can't read it very well -- but what we did there is we divided out-of-pocket spending into a number of components, supplemental insurance, Part B premiums, prescription drugs, medical provider, home health care, inpatient care, outpatient and other services, and calculate the mean level of spending within each of those components.

As you can see, supplemental insurance and Part B premiums are the two largest sources of out-of-pocket spending. As far as actual medical care services are concerned, medical care provider services are the largest source of spending.

We believe this is a pretty informative diagram but we also believe there are ways we can improve upon it.

One problem with displaying just the means is that the distribution of out-of-pocket spending is skewed. That is, there's a large portion of the sample that's at the lower end of the distribution and a small portion that's at the very high end of the distribution. In such distributions, the mean may not always be indicative of the spending by a typical beneficiary.

For example, in the living non-institutionalized sample, we find that the mean is about 20 percent above the median or the middle score. Therefore, we think that the presentation of mean out-of-pocket spending could be improved if we use some different measures of central tendency, such as median values or just choosing the beneficiary who has the median out-of-pocket spending and using his or her spending data, or what we view as the most promising alternative.

What we have here is what we did is we ordered the living non-institutionalized from low to high based upon their total medical care expenditures. Then we divided them, based upon that variable, into a number of percentile ranges, zero up to 10 percent, 10 to 25 percent, 25 to 50 percent, 50 to 75 percent, 75 to 90 percent, and 90 to 100 percent. And we calculate the mean level of out-of-pocket spending within each of these percentile ranges.

I really like this diagram for a number of reasons. First of all, it's got a lot of flexibility. What we could do with this is we could divide the sample into a number of subcategories based on the beneficiary characteristics and do the same thing as this within each of the subcategories.

Another thing we could do, as we did in figure five of the mailing, is show the mean spending within a bunch of components that make up the total spending in each bar.

The last thing is that this diagram shows both dispersion of the distribution, if you look at the high end, and the low end. You can really see there's a lot of difference between the spending at the low end

and the high end. But at the same time you get a real strong sense of what the central tendency is by looking at the percentile ranges in the middle of the distribution.

Another way that we view that we can improve upon the mean out-of-pocket spending presentation is to include a time dimension. First o fall, as you go through time, the level of spending on one particular service might be changing relative to others. If you know that information, on how this relative spending is changing through time, that can provide sort of an early warning device about what sorts of issues we may need to be concerned about in the near future.

Second of all, in every year there's always going to be a group of beneficiaries who have a real high level of spending. For some of the, that's going to be a persistent thing. They're going to have high spending year after year. But for other beneficiaries it's a very temporary thing. Therefore, we think it would be useful to consider spending not over a single year but over a multiple number of years. The MCBS will allow us to do that.

One thing that we did find is that when we consider out-of-pocket spending over a three year period rather than one year, we found that the distribution of that out-of-pocket spending is less skewed over the three year period than the one year period.

A final possibility for improving the mean out-of-pocket spending presentation is to include other sources, such as Medicare and supplemental insurance, in the analysis. Doing so might provide a different perspective towards how we view out-of-pocket spending. For example, for the living non-institutionalized, we found that Medicare pays 60 percent of their total expenditures, and that's the largest source of payment. While out-of-pocket expenditures are the second largest source, they're well behind Medicare and they cover just 16.4 percent of expenditures.

Next I'll discuss the other common method that's been recently used to measure financial liability, that being the value of out-of-pocket spending to beneficiary income. This diagram here is straight from a study by Marilyn Moon and some of her other Urban Institute colleagues, where what they did is they used data from

the 1987 National Medical Expenditure Survey, the NMES, projected to 1996 levels. And they divided the Medicare sample into a number of income-to-poverty ratio categories and calculated the mean value of the out-of-pocket spending to income ratio for each of those poverty categories.

What they found is that in the lower poverty categories, in the poor and the non-poor as they have up there, they tend to spend more of their income on out-of-pocket medical expenditures than what the people at higher income-to-poverty ratios do.

To make this presentation of out-of-pocket spending/relative income meaningful, we believe that we should use family out-of-pocket spending and family income rather than individual beneficiary spending and income. Moon and her colleagues did just that, but we also believe there are ways that we can improve upon their presentation, two of which are quite similar to what I just discussed in regard to the mean out-of-pocket spending presentation.

First of all, in the numerator of the ratio you have out-of-pocket spending, and as I just said that's got a skewed distribution. Therefore, the ratio of out-of-pocket spending to income probably also has a skewed distribution. So therefore it might be useful to supplement the presentations of the means with a representation of the distributions such as showing the out-of-pocket spending to income ratios at various percentile levels.

Another thing we can do to improve the presentation is to include a time dimension because, once again, every year there's going to be some beneficiaries who have a high ratio. And once again for some

of them it's going to be a persistent thing, but for others it's not. So therefore it might be useful to consider data over a number of years rather than a single year.

There's also two adjustments to the presentation of the out-of-pocket spending to income ratio that are unique to that ratio. First of all, we'd like to find out how this ratio has been changing over the years because this, once again, can provide another early warning device about an issue we may want to look at closely, if not now into the near future.

Finally, the final adjustment for this ratio would be to include the value of Medicare and other in-kind transfers, such as Medicaid, as part of beneficiary income. The easiest way to probably do this is just to calculate the mean reported values of the in-kind transfers and tack those means onto beneficiary income.

A shortcoming to that method is that it obscures case-by-case differences. For example, older, sicklier beneficiaries are probably going to value Medicare more than younger, healthier beneficiaries. Second of all, there's practice pattern differences and price level differences between regions. To the extent that these differences exist, the value of Medicare is going to differ between regions. Finally, there's a wealth effect in the sense that wealthier beneficiaries will generally find an easier time to self-insure if they didn't have Medicare while poor beneficiaries would have a more difficult time. So probably poorer beneficiaries value Medicare more than wealthier beneficiaries.

Judy and I will address these issues to the best of our abilities, but at the current time we're not certain how effectively we can do so as far as addressing all of them.

For basically any financial liability analysis, a final improvement we'd like to make is we'd like to include other populations outside of the living non-institutionalized because other populations don't necessarily have the same out-of-pocket spending profile as a living non-institutionalized. For example, as we

show on this diagram, we divided the MCBS sample into the living non-institutionalized, the living institutionalized, and beneficiaries who died during the survey but did not spend any time in nursing homes or other long-term care institutions.

The institutionalized and the decedents indeed have larger mean out-of-pocket spending than the living non-institutionalized, so it might be worthwhile to investigate those two populations in more detail.

To summarize our intentions for our short run analysis, in particular the June report, we intend for the analysis to be somewhat similar to recent financial liability analyses. But we will include some or all of the improvements that I just discussed and any other improvements that the Commission would like to recommend and have us add to it.

But also, I think it's useful to investigate alternative databases because the MCBS does have some shortcomings, especially in regard to the out-of-pocket to income ratio presentation. By that I mean in the MCBS, out-of-pocket spending is reported at the beneficiary level, while at least for married beneficiaries the income is reported jointly with their spouse, so there's an inconsistency there.

A viable alternative could be the medical expenditure panel survey from the Agency for Health Care Policy and Research, but we're not certain if that data will be available in time to be of any use to us. They're running a little behind in producing the data. So therefore we may have to turn to alternative databases, such as the consumer expenditure survey.

Now I'll turn it over to Judy and she's going to cover some of our grander visions and some of our modeling goals.

MS. XANTHOPOULOS: With respect to the short term work that I plan to do there are two main things. The first one is that I would like to make a classification by use of services. I think basically the aggregate classifications obscure a lot of important information. We're looking at means spending by non-

institutionalized. However, there are great differences between different segments of the population and I would like to, using some of the diagnosis codes and sort of bundling the visits, I would like to look at Medicare beneficiaries by their use of service and look at categories of individuals to see what kind of a liability is imposed on those people. Who's actually benefitting? Who's paying a considerable amount.

I think that this will hopefully be able to identify two important categories here. One is when we look at the draft that Dan had put up. If you look at this one, you can see that supplemental insurance is the largest category for means spending for beneficiaries. One of the things, by identifying beneficiaries by their use of services, we'd like to look at those that are just spending on supplemental insurance but maybe don't have a high utilization.

So those people I would like to look at separately from individuals that actually have high use of services, have high out-of-pocket, maybe don't have supplemental coverage. I'd like to be able to break them out separately and look at those different categories.

The second thing is to identify certain at-risk populations in Medicare, specifically those with catastrophic illness, chronic disease, or terminal illnesses. Those tend to be categories of individuals that would have higher than average expenditures and I'd like to look at those groups and see if we can glean anything more than looking at the mean, at the aggregate means of all the different categories.

The next thing which is somewhat related to this is that I'd like to link the MCBS annual files. The beneficiaries say in the survey until they're deceased or for other reasons may drop out. But nevertheless, we have the ability to link up actual beneficiaries from year to year.

I think that this will give us an opportunity to address the persistence issue that Dan has raised in his discussion, when you actually have the same person year after year looking at their expenditures. We can do several things. We can look at those who may have had a catastrophic illness and look at their

expenditures in subsequent years. We can look at their spending patterns for people with chronic disease, chronic health conditions, and try to see what type of pattern persists for them.

The other thing is that we can observe those at-risk groups over time. We can also break out the trends in the increases in the spending, whether there are price components, things that are driving changes in those different components. But nevertheless, linking the beneficiaries, linking the annual files, will give us a little bit different perspective of the beneficiaries' spending pattern.

The other thing that I'd like to do is to enhance the MCBS with supplemental data sources. As Dan alluded to there are a lot of problems in the definition of income in the MCBS. It, at times, will understate income. There's also information that some beneficiaries -- not all, of course -- have had increases in income and wealth over time. Those are things that are not captured in the MCBS. We really don't know. An individual can have very low income but actually be quite wealthy, be financially well off and have considerable assets.

So one of the things I'd like to do is to do a soft match with the MCBS, which would be to identify identifying characteristics and merge the data sets, like attach certain variables from one areas is the statistics of income, the tax return data, which you can get very detailed information on an individual, and actually merge the tax income information onto the beneficiary data. That's one example of one of the things we'd like to do to enhance the data.

Those are the short run things. It's primarily a data enhancement and the other one is a different way of looking at the MCBS file over time. That's the short run work.

The future modeling plans, we'd like to ultimately have a microsimulation model which would have the demographics and the characteristics of the Medicare beneficiaries and it would capture the

insurance markets, the insurance aspect of Medicare, the other supplemental markets. We'd like to be able to have all of these as stand alone models that integrate into one functional model.

The questions that we'd like to be able to answer would be the effects of spending on benefits changes, so we'd take a change in Medicare benefits and see how that would affect individuals in the model. So by basing it on a microsimulation you have the characteristics at a microlevel but you can aggregate up to the total population.

The other thing is to look at beneficiary use according to benefit changes, which would get to the access issues. The longer term things, the financial impact of the chronic disease, catastrophic expenses, and also Medicare only coverage, expenses in the final year of life. Those are the types of things that we think in a model we would be able to get to the dynamics, to look at those changes over time and actually be able to make a statement in the aggregate.

The other thing that we would hope that our model might be able to address might be things like changes in the age of Medicare eligibility, which is something that while right now this is not a concern for a lot of our analysis, it may be something that is out on the horizon that we probably would need to address.

The other thing is changes in benefits packages, which is another area where clearly right now we're not looking at this but in time it may be something we would have to look at.

The last slide, talking about the model, is we want to be able to distinguish between types of spending and we want to identify the classes of spending which are burdensome and then also try to be able to have a model which we could determine an optimal level of spending and insurance coverage for beneficiaries.

That's the overview of everything we have and we'd be glad to answer your questions or comments and suggestions.

DR. NEWHOUSE: Let me start by saying, I like several things about what you've done. I like the linking over time. I like treating the means at various percentiles. I like the broad definition of income. I think you've added a lot of value to this kind of analysis.

Let me give you three reactions of one thing I'd like you to add and two things I'd like you not to do that you say you want to do. I'd like you to add the long-term care side and Medicaid. It seems to me if we're talking about how well public programs are protecting people against financial hits that we have to include long-term care. And just doing Medicare is too partial a picture, particularly sense you're putting a lot of effort into improving just Medicare.

So I'd rather have you, if anything, back off and do a cruder job on a broader issue or fine if you can do the refined broader issue.

Then the two things that you want to do that I would ease up on, and we'll see if other people agree. One is the decomposition of the increases in spending into utilization and inflation. I don't have any problem if by inflation you mean general inflation. But if you're really going to do utilization, you must mean medical care specific price indices; is that right?

I just don't think they're up to the task for a lot of reasons. Medical care price indices, I think, are likely to make large errors, for example, if site of service shifts from inpatient to outpatient or it shifts from say surgical treatment to a drug treatment that results in a decrease in the cost of treating an episode, the price index doesn't register that. If there's a quality enhancing but more costly method of treating something it registers as a total price increase.

MS. XANTHOPOULOS: Can I ask you a question about that? Because one of the problems with -- I understand the limitations of incorporating those into your analysis, but there's also a

question of how do you -- you may not be able to discern where there is a quality improvement that is costly, but we would be able to identify a trend.

One of the things that we're concerned about is there are limitations with the timeliness of some of the data sources we rely heavily on. That might be able to look at other trends and other indices to give us an idea where one has been growing. Maybe that gives us an idea -- we may not be able to break it down into the proper --

DR. NEWHOUSE: The issue is, do the price indices measure what they purport to measure? In my view, they don't. It's critical that they do measure it because any error in the price index translates into a corresponding error in the quantity measure when you decompose. If we were talking about small errors that would be one thing, but I don't think we're talking about small errors here.

A third thing is that you, in principle for what you want to do, need transactions prices. And although the intent is to get transaction prices, in practice they rarely get them. That is BLS and BEA rarely get them.

So I don't think the price indices will sustain the burden of the analysis you want to do.

This is a much more minor thing. I wouldn't worry about doing simulations with the absence of Medigap. I don't think Medigap is going away. I'm not sure what we're going to show, what we think we're going to learn from doing an analysis of what would happen if Medigap were just abolished, but maybe you had something in mind.

MS. XANTHOPOULOS: One of the things that we've been at least looking at when we look at out-of-pocket spending is that it's such a large component. I guess one question is, which as you say it may be sort of a gnat in the face of this problem, but it seems that there are spending in categories of the classes

of Medigap that are rather costly, and it's not clear that beneficiaries are getting a return on those dollars that they are spending. They're not actually using the services for which they're paying. I was just curious.

DR. NEWHOUSE: That sounds like a different analysis than what you've got. As I read page nine and listened to your presentation, you were going to do a counter factual and suppose there weren't Medigap what would out-of-pocket spending be?

MS. XANTHOPOULOS: For those specific individuals.

DR. NEWHOUSE: Well, is anybody going to be interested in the answer?

DR. WILENSKY: You raised the point, or I guess it was in here, that people appear to be buying the most expensive plan that includes excess physician charges.

MS. XANTHOPOULOS: Less than 5 percent actually incur those expenses, yes.

DR. WILENSKY: But if you wanted to really look at that kind of analysis, you'd have to do something very different from with and without Medigap.

MS. XANTHOPOULOS: Yes and no. I guess what I'm thinking is I'd like to look at those with high expenditures for supplemental insurance -- not just Medigap but supplemental -- and see what their spending would be like in absence of that.

DR. NEWHOUSE: You mean absence you mean some other -- you say the absence of supplemental coverage so I took that to mean it just went away. But if you mean some other supplemental coverage, I could see that being potentially more interesting.

MR. SHEA: Can I just make a point on this? It seems to me there's another factor here, and I'm not sure if it's in the data or not, and that's what's happening to retire provided and paid for supplements versus individually purchased supplements. We're in the process of a big shift where a lot of employer-provided coverage is disappearing pretty rapidly.

MR. ZABINSKI: In the diagrams where we say supplemental insurance, that's both Medigap and employer-provided.

MR. SHEA: So it's whoever's paying for it is included there and both have out-of-pocket?

MR. ZABINSKI: Whatever the employer covers, that's not out-of-pocket but if the beneficiary is receiving something through their employer but paying some part of it, that goes into out-of-pocket.

MR. SHEA: This is along the point.

MS. ROSENBLATT: I want to agree with what Joe said. I think you've taken this financial liability issue, you've suggested some very good stuff and I think it's a very good and ambitious workplan and I'll talk about some of the areas where I think it's ambitious.

Like Joe, I think adding the additional definitions of income, adding the interest income and the capital gain on assets, I think is really important and will really improve the analysis and what the measurements really are. So I thought that was excellent.

I also thought, looking at it over time, is excellent, because you do have a lot of people that go through periods of high expenditures one year, low expenditures another year. So I thought bringing in the time point of view was very good.

In terms of the analysis categories, and this may get a little bit at what Joe was talking about, I would suggest instead of just looking at a category, those who have Medicare supp versus those who don't, you may actually want to further categorize each Medigap policy. There are only 10 of them. It would be interesting to see what are the differences between which of these 10 plans people are buying.

My biggest issue, in using the word ambitious, I think this microsimulation model that you're talking about building is a very ambitious future workplan and it's getting at some of the issues that the

Bipartisan Commission are looking at, like what happens if you increase the age? And what happens if you change benefits? I would just add lots and lots of cautions, that in a lot of models like that, and we talked about this last time when I asked to have a model on provider payment done, your assumptions on what will happen drive a lot of the results.

So you have to be real careful to produce a model like that that's really going to be a value and that's not going to leave you open to attack because of the assumptions that you make.

Two minor kind of clarification things. There's a footnote on page seven of the material that you gave out that says further, Plan F has a lower average loss ratio percent of premium returned in the form of benefits. Compared with that of Plan C, the average loss ratios

are 75.5 and 89.3 percent respectively.

This may be something where my knowledge, number one, may be out of date because I haven't done work on these plans in a long time. Or I may have too much knowledge, but let me just tell you what may be happening. You may be seeing what I would call risk selection in a given carrier between the different risk plans. And if I remember OBRA correctly, OBRA requires that each plan be priced on a stand alone basis.

What will tend to happen is that the sicker people will select the richer benefits. And then you can't charge a beneficiary or an insured more for something that's got less benefits, so you're artificially driving up -- to have a consistent gap that represents the benefit differential you sort of artificially drive up the cost of the lower benefits.

Bill's nodding his head. I hope I'm making sense here. Anyway, that may be what's driving this loss ratio.

The reason I'm bringing it up is it may just, by just having it there without the whole background I'm talking about, may result in people jumping to strange conclusions. And there's a very -- risk selection is probably what's doing it more than anything else.

The last thing is figure two has a bar that's labeled Medigap and employer. I didn't really understand what that was, so I'd just like clarification on that.

MR. ZABINSKI: On the Medigap and employer, all that means is people who have both Medigap coverage that they purchased on their own and coverage purchased through their employer.

MS. ROSENBLATT: I guess that's where I'm really having problems because if somebody's got coverage through their employer, why would they also purchase Medigap on their own.

MR. ZABINSKI: That's a good question. Perhaps their employer coverage isn't very good. I don't know, but they do exist.

MS. ROSENBLATT: That may be something else we want to study, why do people have both of those because it would sound like to me that's kind of a wasted expenditure.

MR. MacBAIN: For the drug coverage?

MR. SHEA: I think there is a fair amount of this double -- it's not duplicate coverage, but it's more than one policy. And I think there will be more of it because of what I was referring to before and that is the retreat of employers from providing supplemental coverage.

Because of the FASB rules and having to book the projected cost, many employers back five or six years ago put in limits on their contributions and they set them at

a pretty generous amount. But when those limits are hit

in 2000 or 2002, I forget exactly where the projections are, then all the additional costs are going to go to individuals. So I think you're going to see a big shift from employers to employees among the retiree population for the supplemental.

So I think it is important to understand what it is that we're looking at in this area and I think you need to look at both to understand the trends.

I think that's one trend of a couple I wanted to mention. We've talked before about what's happening with the managed care option. Clearly we're seeing, although we don't know the dimensions of it yet, some shift in cost to individuals because of reduced prescription drug coverage or other supplemental benefits in the managed care arena or increase in the out-of-pocket requirements. So I think that's another current trend that needs to be followed.

The third in that category, I'd say, is the drug costs which seems to me to be the big 800 pound issue here over the next few years. This is a big issue now in current and active worker coverage. It seems to be a big issue behind some of this HMO problem we're talking about and I think it's going to be a huge issue for retirees, and therefore for the program soon.

I have a couple of other points, but let me just say I thought I'm adding some things that are current issues and may be beyond the scope of the data certainly. I don't know how you incorporate those, but I wanted to say that I also thought this was a very nice piece and is a good example of the kind of work I thought we saw earlier this morning, that at least from my point of view sort of let us talk here about what is it that we're looking at? What are we trying to get to?

That really, I think, is the beginning step towards doing this. Obviously, we've got to get to the quantitative analysis and so forth. But I just like this kind of piece as a starter. I think it's a good view.

I did want to raise one caution, though. In refining the data, when you talk about somehow trying to include the value of Medicare, that raises a concern with me beyond including other income sources. My question would be are you planning to just make these changes? Or are you planning to look at a valuation with it and a valuation without? Because I'd like to see how this comes out.

MR. ZABINSKI: I would say the latter.

MR. SHEA: It's not immediately obvious, if you're talking about financial liability, why you would want a value or how you would value Medicare. It's an important concept obviously, in terms of the value of the whole system but it's not exactly the same as money in and money out.

MR. ZABINSKI: That's right. It's obvious there is a value to people of Medicare. Because they get it they're able to partition their income differently than if they didn't get it. So obviously it has a value to them.

Measuring that sort of thing, though, has been a tough thing for economists for a while. As far as I know, I'm not sure if it's been effectively done recently but when I was in graduate school it hadn't been.

DR. WILENSKY: It's been done in Medicaid, an evaluation done on Medicare I think.

MR. SHEA: It just seems to me it's a different order of look at this, and a very important one. But given the reports that we have of high out-of-pocket costs for certain people with modest incomes or even very low incomes. I think that the immediate impact of financial demand for needed services is the most important first cut, which I take it is what you're going after here.

I have a couple of other points that I'll just send you a note about because they're very small. I'm just trying to understand some of the figures you used.

But I want to raise one last issue and that is I would just encourage you to look at, as you go through this and try to refine and measure to make sure you're capturing all the income from this, also look at

where the figures might be underestimating the actual cost measures compared to need. Certainly among the low income people wind up making choices, and there's plenty of anecdotal evidence that the choice is sometimes that they don't purchase. Therefore it wouldn't be captured, in that they don't expend the money to get services that someone recommends they have.

Putting aside whether they really need it, I think we can assume at least some of that is valid care that is forgone because of lack of income. I wonder if there's some way to capture that somehow or at least note that to the extent that we can do so with some accuracy or credibility, estimate what the dimension of that problem is.

MS. XANTHOPOULOS: We can look into it. I'm not sure off the top of my head if --

MR. ZABINSKI: Yes, stuff like that I find really interesting to look into, but then I always say well how am I going to do that. Well, we'll look into it.

MR. SHEA: It seems like even if we were able to look at among certain income levels how monies were expended, you might be able to draw some inferences from that.

MS. XANTHOPOULOS: With respect to the use of services, clearly there will be an office visit, there can be tests, there can be things associated with one service, one event. That may be one way to look at it, in terms of someone with the same diagnosis had certain work done and someone else didn't. That may be a good way to look at it. But I don't know if there's anything in the data that reports services declined or something like that. That's something we'll look into.

MR. SHEA: Thank you.

MS. NEWPORT: Just a couple of questions. On your mean spending by category graph, does that include all classes of beneficiary, whether they're in fee-for-service or managed care? Is that every one or is your sampling limited to fee-for-service?

MR. ZABINSKI: That's what they call the living non-institutionalized. It can be fee-for-service or managed care.

MS. NEWPORT: I have to align myself with everyone else, I think this is very valuable and find it very interesting.

One of the things I was thinking about and I don't know if this has any validity. For example, in the prescription drug category it occurred to me that since not all drugs are covered by Medicare, is maybe looking at this in terms of out-of-pocket spending by Medicare covered services versus what some people call optional supplemental, but they're not really optional they're just not covered.

I think that that might be potentially another way to take a look at what the out-of-pocket variability costs might be categorized that way. It may not have any value at all, but it occurred to me that there's sort of a mixed metaphor here a little bit, in terms of maybe looking at the range or degree or percentage of income devoted to those types of things.

I can't find the footnote now, but I seem to remember a footnote talking about some problems with some managed care data because of a point in time. Did I misinterpret that? Why don't I defer and let me find it and I'll ask you the question.

MR. MacBAIN: Two questions. One of them is a point of clarification. The data base you're using, are all of those beneficiaries covered under both Part A and Part B, throughout the entire survey period.

MR. ZABINSKI: No, they could be one or the other.

MR. MacBAIN: Is there a way to control -- what got me thinking about this was in figure five the highest decile, the piece that expands most rapidly is medical provider and it appears -- though it's hard to tell from the graph -- but it appears that the Part B premiums actually decreases slightly from the prior bar

which suggests that part of that increase, as you move from one population to another, may be the logical consequence of not having Part B, not having a lot of physician expenses in that year which is a different question, I think, than the one we're trying to answer.

If people have chosen not to select Part B when they're first eligible for it, that's going to have some consequences that are different from trying to measure the overall adequacy of Medicare.

MR. ZABINSKI: I want to say, yes, we can control for that. I'm not 100 percent certain.

MR. MacBAIN: It would be worthwhile, if not, at least to have a footnote in the information saying we don't know in this population but we know, in general, that 87 percent of people who are eligible for Part B take it, or whatever the number really is, which is trying to get a sense on what's going on there because that really could skew your top decile, particularly for one year data where the second year they go out and buy it but in the meantime they've incurred all that expense.

The second question is on that footnote on Plan C and F, because that struck me as fascinating. It's probably outside the scope of what we're doing but it got me wondering whether the choice of F over C is a function of the plans that are authorized in given states? As I recall most states don't authorize all 10 plans. Have states tended to limit -- particularly populous states -- their choice to plan F to the exclusion of plan C, given that the benefits are so similar?

If so, is this simply a function of state policy rather than beneficiary choice or irrational choice or marketing behavior on the part of insurance companies?

MS. XANTHOPOULOS: It may be a combination of all of those I suppose. But GAO did do a study. They got the universe of the NAIC, the data base for all of the providers of Medigap insurance and they actually went back and verified the data for several years and looked at this.

One of the things that they came up with was I guess the point was that perhaps it might be -- it may be a marketing thing as opposed to maybe an irrational choice. But it may be that this is something that's marketed that is not really needed. And there's a considerable difference in the premiums.

MR. MacBAIN: My point though is if you stop looking at it in aggregate and look at it state by state, and if the 10 or 15 most populous states all authorize five of the 10 options, among with is plan F but not plan C, you'll get the same result. It has nothing to do with people's choices.

Related to that, too, and this has to do with Joe's comment on including Medicaid, is the need to control for the effects of state policy in the Medicaid component of this. Again, that could be a significant enough component of the overall spending that we might see differences that don't have anything to do with anything except individual state policy, which is interesting but I think we want to separate that out from other factors.

In your future modeling, one of the changes to Medicare that's been proposed is a move to a defined contribution program. I'm not sure how you try to deal with that. You talked about trying to measure the effects of modifications in benefits, which is what I would expect to be the outcome of that.

You might take a look at whether there's a way to shed some light on what the likely outcome of a defined contribution plan would be.

DR. KEMPER: I agree with many of the previous comments, including the one about the analytic approach. Also the comments that it's a very ambitious agenda, and thought about how to sort through which things are top priority.

It seems to me the most important question is -- there are really two. How well is Medicare doing with respect to insuring, and particularly with respect to high losses? And so I would urge you to add some measures that would look at how many people have very high expenses or very high expenses as a

proportion of income, those kinds of measures as well as your means within the middle percentile, which is a nice advance. But to look at the -- I don't know if you want to call them catastrophic -- but the very high expenses and over a series of years which I thought was a nice addition.

Secondly, how is that changing over time? And is it getting better or worse? Both the averages and covering the catastrophic costs.

Given that you have a number of improved measures here, going back and getting the time series could take a fair amount of work. So it strikes me that those basics, and particularly the time trend dimension, ought to take precedence over building a simulation model, for example, which is a very ambitious and time-consuming effort. And maybe some of the experimentation with other data sets and so on, just to get those basics done.

The other comment is I agree with Joe that it's really important to look at the long-term care and Medicaid. But it seems to me that that should be done initially in the chapter, but then a good chunk of the presentation ought to be limited to what Medicare is designed to cover. Because in a sense you can't make Medicare accountable for long-term care expenses.

So while I think it's important to provide that context, and it was one of my first comments here, then I think much of the work has to get rid of the Medicaid and the long-term care so that you can track what really Medicare is designed to do.

DR. WILENSKY: Let me just extend along that line of what Medicare was designed to do comment. I think that the emphasis on not just out-of-pocket but on the "catastrophic" coverage issues, which you raised in the beginning of the chapter and Peter has just raised here, is very important. But I think when you do analysis, or maybe the presentation, you'll need to put it in a context that at several points in the history

it's been suggested that Medicare could be redesigned to be a more sensible insurance plan in a budget neutral manner. And that there was not an interest in doing this.

So again in the context of judging it in terms of what it's intended to do, it's not just that there are catastrophic expenses that aren't covered, and we need to know the dimensions and whether it's growing over time and how it varies by income, but the fact that this was in some ways -- I don't know whether explicitly not included or at least when the opportunity was raised on at least two different occasions in the early '80s and the late '80s to do so, it was put aside for various reasons.

In that vein though, as a suggestion, it seems to me that MCBS is a much better data source for you for a lot of reasons than some of the other data sets. It's true that people have aged from the 1987 data base, but you can age the MCBS as well as they age the '87 and you've got eight years in your advantage when you do so. Plus the fact that it's a much more relevant sample if you're interested in things like catastrophic, for example, or other areas where you'll need a bigger sample than you're likely to get from the '87 survey.

So I think that using the soft match, I was asking Murray whether that's akin to a cold-decking sampling strategy that the Census talks about, but trying to match up with the statistics of income or other income, that it would seem to me to be far preferable than the earlier data set.

Also, as it becomes available over time, you will be able to build a base over time from the MCBS that will be much harder if you look at the 10-year survey. So using that as the basis for doing analysis in the future seemed to me to be a much better idea.

MS. XANTHOPOULOS: Yes, I don't think that we intended to rely on any other primary data source. I think that Dan and I had talked about just using -- there may be areas within one set that presents one or two variables better than the MCBS but I think you're right, that the MCBS is the --

DR. WILENSKY: One other comment and then Joe had another comment.

This is something where it may take a little more discussion outside of your presentation. As positive as I think the analysis that you included here is, and exciting for what we can do, I have a little concern about balance and relative priorities of some of the issues being raised here versus some of the other issues that the Commission has to deal with.

It will only be a question of how to try to best handle this over time and working with you and Murray and some others to try to make sure that our creative modeling gets put in the place we need it first or most early on. It's not a question of not doing it, it's just how quickly can you get to some of the more creative and interesting aspects of the modeling that you've laid out?

Some of it may be once you have your data constructed you can do a lot, or during the summer or during other times when we have some of our greater down time -- this summer notwithstanding -- it may be possible to be able to do some analysis and also to do some of the valuations of Medicare, which might be much more for your own use.

I suspect the likelihood of getting agreement from the Commissioners, just given the literature at least as I know that has existed in terms of value in some of the transfer programs, is going to make it difficult to use it for the Commission work but it may be very important in terms of trying to move forward some of the analysis that are available in the literature.

DR. NEWHOUSE: I'm not sure the data will be sufficient to support this, but you might take a look at whether things are different by basis of eligibility. That is, are the disabled and the ESRD people different from the elderly on this dimension?

A little bit in response to Peter, at one level I don't really differ with him, given the charge of our commission, we have to look at Medicare only. But I think we may differ in degree of emphasis. That is, to me, kind of refining the estimates of what Medicare only does for protection is a little like improving our

measurement of how well the roof is covering the living room but not doing anything about how well it's covering the kitchen.

DR. CURRERI: I'd like to refer to your Figure 2 which I found one of the more interesting graphs. I really want to focus on the first bar there. It seems to me this is a very dishomogeneous, or heterogeneous population. The reason I say that is because if this were HMOs you wouldn't have any supplemental insurance. And if this were purely PPOs and IPOs you'd have probably a large pot of supplemental insurance.

If it were HMOs, my guess is you'd have no inpatient costs and you would have bigger inpatient costs if it were PPOs or IPOs. And I would guess that in an HMO you'd have much less prescription drugs than you have here.

So it seems to me that's an inappropriate grouping and it's very misleading to me anyhow, because I think that the IPOs and PPOs, if you going to group them with anything, they would be better grouped with the Medigap population or separated out. But right now what you have is sort of an average of this very heterogeneous population of people in terms of out-of-pocket costs.

DR. WILENSKY: Wait a minute, this can't be. There's got to be something wrong with this. In 1995 you didn't have PPOs.

DR. CURRERI: Yes, they had PPOs.

DR. WILENSKY: Under Medicare?

DR. CURRERI: Oh, okay.

DR. WILENSKY: I don't think under Medicare. I think what you have here is people who are managed care. You were right, there's a problem but I think the problem is that this is not --

DR. NEWHOUSE: That status as of the time of the survey.

DR. WILENSKY: Right, this was status as of the time of the survey and these were costs that had nothing to do with managed care.

MR. ZABINSKI: Right, it's an annualized variable.

DR. CURRERI: So what's the reason for this big supplemental insurance here?

DR. WILENSKY: Because they're people who weren't managed care all year.

DR. NEWHOUSE: Right, they were managed care at the time of the survey but then they asked how much did you spend.

DR. CURRERI: Anyhow, it just doesn't make sense.

DR. WILENSKY: That was the point that I wanted to agree with you, is I don't think this is consistent with the facts.

MR. MacBAIN: The point is this was '95 when it was not that uncommon for Medicare managed care plans to charge a premium.

DR. WILENSKY: I don't believe this kind of premium in Medicare managed care was in 1995, especially as an average. I don't know what it is, this number does not pass the sniff test.

MR. ZABINSKI: I agree. It's exactly what you said, it's an annualized variable. As far as teasing that out, exactly what to do. I mean, I think it's possible to like, if somebody's a part year fee-for-service, part year managed care, maybe if they do six months of one and six months of the other, I think the data is available where we could like make them half of a managed care and half of a fee-for-service. I think that's possible.

DR. NEWHOUSE: That doesn't really solve the problem.

DR. WILENSKY: You could get, just as a check --

MR. ZABINSKI: That's right, Joe.

DR. WILENSKY: You could get, as a check, from HCFA in 1999 weighted average participation in HMOs. They know, just in terms of the number of people who are in HMOs and whether they charge premiums.

As I say, you wouldn't have to do even a really careful calculation. I may be wrong but my guess is this is not within the relevant range. I don't think it's anything like $1,500, I don't think. I may be wrong. It may be coverage for pharmaceuticals that is limited that is driving this up.

DR. CURRERI: Would there be any inpatient costs?

DR. WILENSKY: Oh that's inpatient. That's true. Yes, I think it's part-year managed care. It looks like a very funny number, given that the kinds of plans where you would expect to see that didn't exist in 1995.

MS. NEWPORT: It may be biased because some plans will have three options, and if they just took the high there will be some premiums. So it may not be averaged over what the plan selection was by a bene within an HMO.

DR. CURRERI: Are there any copays for inpatient services?

MS. NEWPORT: Sometimes emergency, sometimes emergency room would be $50 to $75.

DR. CURRERI: That's not inpatient.

MS. NEWPORT: I don't know. That would be the only thing that I would...

MR. MacBAIN: Just to note, there also appears to be supplemental insurance with the Medicare-only and with the Medicaid, that suggest that these are people who change status in the middle of the year and got lumped in one category or the other.

DR. WILENSKY: Anyway, to the extent there are a couple of these numbers that look very funny, so to the extent you can track it down, talk to HCFA about what might be going, I think it would be helpful. Anything further?

Obviously, a lot of interest in the more creative efforts that have been raised with this area I think were recognized by basically everybody who has commented on it.

Thank you. Beth and Susan?

MS. PHILIP: I'll be talking about workplan for structuring informed beneficiary choice. In this presentation, I'll first look at the Balanced Budget Act requirements, just quickly going over the specific provisions that relate to beneficiary choice. Then we'll take a look at objectives for informed choice and the assumptions that underlie the informed choice process. The last piece will be a look at the components for a workplan, which include the consumer choice model and evaluation of current Medicare initiatives.

Under the BBA and Medicare provisions plans available to beneficiaries were expanded to include coordinated care plans such as HMOs, PSOs, PPOs, as well as other insurance options such as MSAs and, of course, traditional fee-for-service Medicare. With the availability of new options comes the need for new information about those options. The BBA mandated that HCFA distribute information about plan service areas, benefits, access, and quality in a clear and standardized form.

Medicare+Choice organizations must also disclose information regarding coverage, enrollee numbers, information about complaints, physician networks, and other cost and quality measurements. They must give this information directly to any beneficiary who inquires.

There are certain intended objectives in informed choice. One is that informed choice is a value in and of itself. Other intended results of informed choice are that it leads to a higher level of satisfaction

and improved well-being for consumers. And finally, consumers informed involvement in the decisionmaking process should lead to more efficient functioning of the market.

Within the Medicare market the informed choice process should, in theory, create incentives for health plans to respond to consumer needs and preferences through competition.

These objectives of the informed choice process are based on certain key assumptions. The first is that beneficiaries have meaningful choice. In other words, there are options for them to choose from. While Medicare+Choice has potentially expanded options in health delivery, service to certain areas is still limited to traditional fee-for-service Medicare.

The next key assumption is that beneficiaries can obtain information to facilitate choice. They must be able to get information when they need it. HCFA's National Medicare Education Program is currently underway with the dissemination of the Medicare and You handbook to five pilot states and a condensed version, which is a bulletin, was mailed out to beneficiaries in the remaining 45 states.

Other means of disseminating information is also underway through the Internet and through partnerships with state and locally based organizations.

The contents of these materials are also important. They need to be able to answer certain beneficiary questions. For example, questions on the context of the health delivery system, the details of plan options, and beneficiaries also need to be able to answer questions on how these options and the changes affect people like them. In other words, people with similar demographic and health status characteristics.

Once beneficiaries have the information they need, they must be able to use it to make decisions. But it's not clear that they do actually use this information for several reasons. It's important to keep in mind that the Medicare beneficiary population is unique. It possesses certain characteristics that make using information more difficult than the non-Medicare consumer.

Since I've gone into detail in the paper, I'll just highlight a few points. First, one problem with this assumption that the beneficiaries are actually using the relevant information is the literacy rate. Research shows that about 44 percent of the elderly read at the lowest reading level and low literacy rates may be a barrier in using information.

Poor health status, cognitive impairments and reliance on agents to make decisions, these are all issues that we should take into account when assuming beneficiaries are actually using the information they get.

Once consumers have the relevant information and are willing and able to use this information it's not clear that the decisions they make are actually better value-based decisions. A few reasons for this include a lack of comprehension of specific variables and the inability to process several variables at one time.

Another important factor is the presentation of information. Research shows that information presented in different layouts actually can yield different results or different decisions. Also, consumers make health care decisions based on their present health status and they may not anticipate future disability or need for medical care.

The final assumption of the informed choice process is that better choice yields value-based competition. In theory, demand side incentives will compel plans to compete based on costs and quality and then to improve health plan performance. But the question is how many individual consumers need to be informed to have an impact on aggregate demand? It's not clear how much demand side pressure will be required to have such an effect in shifting costs and quality.

Certainly some of the inherent assumptions underlying the informed choice process are problematic within the Medicare market. The workplan we propose will attempt to analyze these problems in

a systematic way. The workplan is two main pieces: the construction of a consumer choice model and an evaluation of the current Medicare initiatives in the context of this model.

The goal of the consumer choice model is to construct a model that will map out the consumer decisionmaking process to identify inputs and potential outcomes. We will do this by drawing on lessons learned from health care and other industries.

The next few points just lay out the method. First, we'll briefly describe the historic change for need. Then we will describe the policy interventions and implementation measures. Then we'll take a look at industry inputs and costs. What's the role of the private sector in this? Next we'll examine the literature to determine whether the goals of the changes and measures have been met. Then we can also convene a panel of consumer information experts to provide insight and perspectives on how informed beneficiary choice can best be fostered.

Just to list some examples we can use in constructing the consumer choice model, the food industry provides an example. In 1990 Congress passed the Nutrition Labeling and Education Act to provide valid and reliable consumer information on food labels with the hope that consumers would adjust their dietary patterns and lower their risk of chronic diseases.

In the health care industry, the literature on report cards of physicians and providers and the use of this information could also be used in constructing a consumer choice model. Within the Medicare market, the 1990 OBRA provisions about Medigap, which simplified and standardized policies, is also an example of changes that affect options and information regarding these options.

The next step would be to evaluate Medicare initiatives. The goal is to identify gaps in information and information needs of Medicare beneficiaries. The method will evaluate these initiatives specifically in the context of the consumer choice model. As mentioned earlier, HCFA has several initiatives

aimed to inform beneficiaries of their new Medicare+Choice options. We'll attempt to evaluate these different initiatives that HCFA is undertaking.

We will also examine work undertaken by state and local based organizations such as the Health Insurance Counseling and Assistance Programs and we'll look at private sector initiatives. Since many employers provide post-retirement supplemental health benefits for former employees, private sector initiatives for informing beneficiary choice will also be considered in the evaluation process.

Upon evaluation, we will identify gaps in information needs and then develop options in filling in those gaps. The resulting analysis could form the basis for a chapter in our June '99 report.

We would appreciate your comments and questions and feedback.

DR. KEMPER: I thought this was a nice workplan, and just one comment which you allude to in the paper, but reading it I get the sense that if all these things didn't happen and most consumers didn't pay attention to it, it wouldn't be a worthwhile effort. It seems to me that just the existence of the information can have a very important effect on the market. Even if 5 percent of the beneficiaries are using it, it could still be very useful in terms of quality and so on.

So I would just make sure that that point comes out because otherwise I think there's a risk that it might be viewed as unsuccessful because of literacy problems and a poor plan and so on.

I just had one question that I didn't understand. You talk about examining industry inputs and costs. I wasn't sure what that was.

MS. PHILIP: For example, in the food industry, what sort of changes did they have to make in terms of labeling? What did the private sector have to do?

DR. KEMPER: What are the impacts on the plans in terms of cost?

MS. PHILIP: Right. That would be the parallel exactly.

MS. NEWPORT: You have quite a challenge. If you can figure this one out, you'll do a great service to everyone. I would suggest that just because that was the last point made, the Nutrition Labeling Education Act, I guess there's one difference between informing people and having an impact on our dietary problems in this country. I don't think we've quite made that leap. After having two cookies at lunch I understand that.

DR. CURRERI: They were unlabeled cookies.

MS. NEWPORT: There you go.

I guess what I'd like to see, in particular, is that we have the five state demo at least out, and what kind of follow up HCFA or you folks can solicit from the bene's as a result of that. I think that it's important, there were a lot of challenges that everyone faced this year. I'm not sure, given the experience of my company, that if given the same doctor they do shop on price, in terms of their benefit program. So it is not necessarily throwing HEDIS or some other quality indicators at people. It is a matter of -- I think you had the right order at one point, price and then maybe quality or price then doctor.

So I think we have to sort of recognize that there is not so much -- maybe it's the Consumer Reporters, where you fill in the circles, a full circle or half full circle or something like that. It might be really simple for people to look at but I don't know that we're really there on a subjective or quantitative basis.

So while I recognize the value of this, and making sure that people have the right information at the right time, I don't know how we get our hands around it, given other studies that show that on average people spend 14 minutes looking at their health plan information. I would say to anyone in the room that's got some kind of insurance coverage, that's probably about the exhaustion of your patience with this, as well. Although the choice is made simpler usually by your employer.

Maybe what I'm saying here is how do we make this simpler, user friendly, and give people the right information? I think our tendency is well, we'll throw more measures at folks as opposed to the right measures.

And I don't have any answers, I just have lots of thoughts. But I would suggest maybe we take a look at the brochures and see what happened in those five states with that, as some point at which to touch the first principles.

Then the Medigap changes in OBRA in 1990, I thought it was interesting that you sought that out as a choice or an example, because I think the change there was driven by the fact that people were being sold five or six policies, and I think it was intrinsically unfair, and it did set some real clear bounds on making a spectrum, A through J I guess it is still. And that's still a lot of choices, but at least it gave some discipline to the market in terms of making sure that people were not abusing the privilege of marketing and remarketing and reselling, so people were treated in a very fraudulent way.

I think that may have been more the purpose there, as opposed to anything else. So I think we need to balance that.

This is just sort of a bunch of thoughts thrown together, but I think we really do need to look at what we're really adding in terms of value and what it means. All these letters, HEDIS, NCQA, no one knows. I even have to stop and think about what those letters mean, in terms of -- QSMIC, I can't rattle that off the top of my head. Even my doctors can't.

So I think that you need to think about how we make it as streamlined as possible.

DR. CURRERI: I found it a little ironic that in your paper and in your presentation you pointed out the high percentage of people that were illiterate and those without cognitive abilities. And then at

the end of the paper you said the major initiative by HCFA is to have their Medicare Compare database on their web page. I tried to put those two things together.

I mean, if we've got 30 percent that are unable to read and another 10 percent or whatever without cognitive ability, and then a major initiative is this, something is wrong in the priorities, I think.

I had two questions. One is do we have any information on how many hits this database gets by the elderly, not just by everybody that's doing research? That's number one.

Number two, is there going to be any attempt to distill what's on the web page and put it down to something that could be easily presented to this one-third of the population that doesn't read?

MS. PHILIP: Actually, about 7 percent of Medicare beneficiaries have access to the Internet.

DR. WILENSKY: How old is that data?

MS. PHILIP: I heard this from Michael McCullen of HCFA, the Center for Beneficiary Services about two weeks ago.

DR. WILENSKY: It's not a question of how recently she said it, it's how long was that?

MS. PHILIP: I'm not sure.

DR. WILENSKY: I only say that because this is the kind of information that if it were based on last year's survey, it could be substantially different.

MS. NEWPORT: And if you've tried to use any of the HCFA web sites recently, it's real tough to find stuff. I speak from a lot of experience on that one.

DR. CURRERI: I know that 7 percent perhaps have access to it, but that doesn't mean that 7 percent have used it. I really think that it's important for us to find out what kind of use it has by the elderly.

MS. DOCTEUR: We can find that out. Let me just add a point that the mechanisms that HCFA is starting to employ to try to inform beneficiaries were laid out in the BBA. So the Congress, in the BBA, said that HCFA would maintain this website, that they would disseminate information through the mail, and then the third approach is, of course, maintaining the consumer assistance hotline. So I think that's the key way that they're going to get at people with cognitive and literacy problems. If they're able to do it, that would probably be the method.

MR. MacBAIN: Another point is I was struck by your reference to research that indicates that consumers only use five pieces of information and try to make a decision, and suggested that for the June report it might be worthwhile spending a little bit of time on how consumers use information as sort of background to try to provide some foundation for thinking about this.

Second is a more specific question, and that is one of the comments in the narrative is that it's not clear that plans make it particularly easy to request relevant information or that they follow up properly. Are you saying that you have specific information that plans don't make it possible? Or just that you don't have information? And if there is information the plans aren't complying with the requirements of the law, I believe, to follow up further on that. Or at least point it out.

MS. PHILIP: Don't have information. From some of the literature that I've come across, it does state that there is a long time from when beneficiaries are actually requesting information and when they actually receive the information. It's just a level of responsiveness.

DR. MYERS: For the benefit of my fellow commissioners, this is not a question to the team making the presentation. We had a lot of experience in this over the last year as the Medicare+Choice plans were coming to public attention. We felt, as did the other autos, that we had to act with respect to our retirees

and did a number of focus groups to try to understand the issue of how did Medicare eligible people want to get their information regarding health plans.

The overwhelming preference was for person-to-person contact, preferably on the telephone, where they could call whenever they had the impetus to call and they could get some knowledgeable, friendly voice that was patient to take them through what the issues were, answer their questions, and then help them to make a decision. Purely from a cost-effectiveness standpoint that's a rather costly option. We learned a lot about what they didn't want with respect to the kind of written information that normally comes their way.

I think it would probably be important, as we go forward with this, to try to take advantage of some of the information that some of the private sector companies have gathered regarding their retiree programs and what the preferences indeed are and what seems to have worked and not worked.

I'm not just picking out our company but there are others as well that you might learn from. I think this is a very tough issue and I think it's quite problematic to make any assumptions about -- especially reading materials and what people are going to get out of them and what they should look like. You really have to have specific examples. You have to test it, you have to follow up with respect to what they felt afterwards to understand what the effects were.

DR. CURRERI: I agree with both Janet and Woody. Number one, I'm not sure that all these quality standards are what these people look at all. Number two, it's difficult to get them to focus on what this really means. I mean, I guess I've counseled over 100 people going into the Medicare program. What they really listen to, to really make their judgments on, is the presentation of whoever's selling the program to them for the most part.

The thing that I find hardest to get across is that the salesperson will say well see, your cardiologist is on here, your surgeon is on here, and so forth, and so on. And they make the immediate

assumption that they can just go to those people just as they had before. And to get through to them the idea -- they get the idea that they have to go to a primary care doctor and they have to be referred. But they think it's only to new services. All their old doctors, since they're in the program, they can just go where ever they want to.

I mean I've spent literally hours trying to explain that that's not likely the way it's going to be under the contract. And they just deny it. It's just a stated denial. So there's a lot of problems with getting this across.

MS. JACKSON: I wanted to ask one question in relation to this statement. It says in 1990 Congress passed the Nutrition Labeling and Education Act to provide valid and reliable consumer information on food labels with the hope that consumers would adjust their dietary patterns, thus lowering their risk of chronic diseases.

I want to know is there any data which really says that this has been beneficial? What has it really done?

MS. PHILIP: We haven't explored that at all at this point.

MS. DOCTEUR: At this point, this is the workplan. It's one of the key questions that we hope to address through this research.

DR. NEWHOUSE: It's done a lot.

DR. WILENSKY: It's not clear that it has -- I mean I think there are two things. One, do people actually look at nutritional labeling. The second, which in our case the parallel would be, would they actually look at the health plan information and then is there any evidence in the food labeling that they're ultimately eating healthier? I think the answer is they're probably looking at more labeling and they're not

eating healthy. Among other things, there seems to be this confusion about whether or not eating lowfat meant you could eat whatever you wanted, and some other issues.

I mean, I think if you look at the outcome information, it's substantially less encouraging than if you look at the actual labeling information. But I don't know whether they've done studies. That's my understanding, at least if what we've found.

MS. NEWPORT: Just to what Bill just said about getting access to physicians and the referrals and specialists. Last spring I gave a series of five speeches to about 500 Medicare beneficiaries. If I tallied up -- this is very unscientific, by the way -- the questions, I spent five minutes talking about the Balanced Budget Act and I said what's on your mind. It's referrals. How do I get referrals? What do I need to do? Who do I need to call?

So it really goes to Bill's point is everyone seems to be perfectly happy with understanding they select a physician who's a primary care physician. But then what happens to them?

If you can talk to them and say this is what the process is, this is what you need to ask your health plan, this is what you need to ask member services, they go away happy just knowing that there is a process and that type of thing. But it's very difficult, when they are looking at the materials -- and remember, these are HCFA approved materials -- you have to have so much in there and so many things and convey so much for them to just sort of get to the high hard information that they really need to feel comfortable.

And I don't care what side of the equation you're on. I think it's what makes them feel like they do have some rights in the system, they do have some choices, they do have a way to rectify problems or issues or get their special needs addressed.

MR. MacBAIN: This is just to follow up a bit on Anne's comment. First of all, strictly anecdotal but a good example, on my way here I bought a bottle of lemonade that had the labeling on the back

and it only had 100 calories, which I felt great about, until I noticed that this one bottle was really two portions. I was thirsty so I drank it anyway. But it points out the difficulty of even a very simple label that may not tell you what you think it's telling you.

Also anecdotally, but I think it's fairly safe to generalize from this is -- and I've mentioned this before -- looking at the effect of reporting hospital cost and mortality and morbidity data in Pennsylvania by a whole slew of DRGs. It's a very unfriendly looking report. There's no indication that health plan beneficiaries ever even see it. I don't think there is yet any indication of employers who really used these data to put together their preferred provider networks.

But it has a real impact on the hospitals themselves. They're the ones who read it. They're the ones who understand the numbers. And nobody wants to be in the bottom half. Part of it's bragging rights, part of it's real concern about quality. People have sort of gotten over the question the data stuff.

So that in looking at the effects of Consumers Reports type information, recognize the health plans themselves are a key consumer. They'll fight for -- it's trite to say bragging rights. I think the point is that nobody wants to be below average. And that bites off another positive effect.

DR. WILENSKY: I wanted to make that comment as well. The fact that this was regarded to the extent that consumers didn't use the mortality statistics that HCFA had put out. That was regarded as a failure on the side of the mortality statistics.

I don't know that there has ever been much of an assessment done but I know that hospital administrators, after screaming in public about how their position was unfair if they were shown in a poor light, would frequently say to me in private that it forced them to try to figure out why that had happened. Whether it was their data collection systems weren't any good or their data reporting systems weren't any good, or there

really was a problem going on in the operating room. Or they thought there really was something about the patient mix that wasn't captured.

And it did force them to go back and to look to see whether or not there was something that was going on that they could impact. It means that to the extent you were trying to make information available on a consumer friendly way, you failed on that criteria, you didn't necessarily do without a positive impact.

But I think we sometimes have to be a little careful about how we judge the effectiveness. That goes back to what people were saying earlier. Even if only a relatively small number of consumers made use of some of the information, we don't know whether that's enough to drive change in the provider community. And you always have this issue that that may be true in 1998 or 1999. It may be less true two years from now if that information continues to be around.

And even when it's a relatively small number, other than trying to make some sort of a cost-benefit trade-off, it's hard to say that if it provides information to a relatively small number of consumers and drives providers not to be in an undesirable category, however that occurs, again it's not having the effect that one might wish to have of making a consumer friendly information set available, but it's not the same as not having an impact.

DR. KEMPER: Just one follow-up comment. I think that's why it's so important what the content is, as well as the process for getting out and whether people use it. Think of the plans and the providers as an audience for the content of the information, as well as consumers.

MR. SHEA: We've talked in previous sessions about other dimensions of this information and consumer decisionmaking complex process. I wanted to suggest that at least two notions, I think, are important to keep in mind and to reflect as you develop this work further.

One is the notion of accountability. That is that, in addition to or a level beyond information on which you can make meaningful choice is the notion of information so that you can provide providers and health plans accountable. Are they really, by accepted measures, doing the kind of job which you expect them to do?

Secondly is the importance of consumer protection. When you get into this area, it's clear from lots of other experience, that you need certain systems to protect people at least from the rough edges of what the jumble of information can provide.

I guess the good news here, again as we've talked about before, there's lots of experience with doing this among private employers. But that I think is another area which really bears some drawing out here. Because one that has not been an easy or an inexpensive experience for employers at all, and they've been doing it in organized groups where they have some control over the negotiating process with the plans and the providers and where they have a relationship with the individuals who get the benefits.

In this situation, it's very important to bear in mind the level of difficulty is much, much higher because this is not a group. There's nobody who says I'm now bargaining, except HCFA with all of their constraints.

And then secondly, just on this cost factor, I think it's really important that, as you say, you look at the cost of doing this sort of thing well because we've already seen that we have an underfunded notion here as we start this process out, compared with what the industry experience has been.

DR. LEWERS: I generally agree with what's been said, but I think there are a couple of issues. One, it's keep it simple. You've got five issues that they look at, you've got to find which five they should look at.

Most of the time if you get over three or four things that people have to think about and look at, they lose total control of it. So keeping it simple is elementary.

Secondly is you've got to make sure it's accurate and that it comes out in a frequent enough form that it's accurate. 20 years ago the Attorney General in the state of Maryland tried this process with hospitals and with physicians. It failed miserably because in our community, when you look up the physicians, they had six doctors in there who were dead and had been dead for some time.

So immediately people said well, if they're that far off, I'm not even going to bother to look at it. And they didn't, and it was published one time and it was out.

But the other thing, which I don't think we've mentioned, is the majority of the people get their information and make their decisions on their family, their friends, their physician and other health care providers. That's where they go. That's what I thought Bill was going to say and, since he didn't, I thought I better.

It's very simple. I mean, I spend a lot of time counseling my patients and I do now, I get a number of phone calls now. I've got this, what am I supposed to do with it? So that's where they go, family, friends, physicians and other health providers. I don't think that's going to change a great deal until we find some system which solves all those problems.

DR. WILENSKY: Further comment?

MR. MacBAIN: Let me just follow up on that because what Ted just said reminded me of a situation with my former health plan. We found that that was a very effective source of marketing that we hadn't even thought of until we got some feedback from doctors who contracted with us, saying I'm recommending you to my patients because I'd rather deal with you than your competitor.

Maybe that's another area to focus on. Why not provide information to physicians to counsel their patients?

DR. WILENSKY: Thank you.

Beth?

MS. DOCTEUR: This final session is the Commission's first opportunity to look at the question of whether and how Medicare, in its new capacity as a prudent purchaser of health care services, should take any steps to address the problem of errors in the delivery of health care.

The staff paper tries to provide you with a framework for thinking about what types of recommendations MedPAC might want to make on these issues, if any. It provides a first cut at the policy analysis.

It starts out with the big picture, in trying to get a handle on what we're talking about when we're talking about health care errors and looking at what theory tells us about error reduction, identifies some obstacles that have to be considered in any initiatives to address health care errors, reviews some of the recent initiatives that have been undertaken in an effort to try to get a handle on this problem. Although these initiatives are quite new, we try to draw some lessons from Medicare from these initiatives. Finally, we move to sort of a case study or an illustration of a specific area in which Medicare might make some changes to its current policies that would have an impact on error, and this is the area of autopsies. So we look at this in a bit of depth in the conclusion.

Health care errors include both mistakes that are made in doing something and mistakes that occur when something should have been done but wasn't done. There isn't an enormous literature right now on the occurrence of errors in health care but it is growing rapidly. We do know that there have been studies in a

number of areas, particularly injuries that result from medical treatment, misdiagnoses, adverse drug events, or mistakes in prescribing medication or administering medication.

From the literature we know that errors are rare but they're not extremely rare. My paper cites several different studies that have been put forward as examples, and also notes Dr. Lucien Leips widely cited extrapolation that looks at what national incidence of health care errors might be. He estimates that approximately 180,000 people die each year as a result of injuries that they receive in the course of medical treatment. He equates that with three jump jet crashes occurring every two days.

A lot of what we know about error reduction actually comes from other industries that have taken the lead in thinking about safety and opportunities to reduce errors. Experts who have looked at this tell us that health care has a long way to go to try to catch up to these other industries. They tell us that what we're going to need to accomplish real change is a real shift in sort of how we think about patient safety.

They tell us that we need to design systems that improve safety and that reduce opportunities for error. They tell us that we need to train professionals in safety methods and to reward professionals for actively taking steps to try to identify opportunities for error.

They tell us that we need systems that provide backup protection from mistakes because human error is inevitable. Furthermore, we need to start thinking about errors as opportunities for learning and exploit them in that respect as much as we can.

Finally, we've learned that learning from mistakes is not likely to happen in an environment in which blame and punishment predominate.

There are at least two obvious key obstacles to addressing error that need to be taken into account in any initiatives to get at the problem of health care errors. The first one is the medical professional culture, which is believed to provide a barrier to addressing errors. Experts who have looked at this issue tell

us that doctors have been trained to strive for perfection, and to have a zero tolerance for error, and not trained to actually look critically at their own work and at the systems in which they work to try to actually identify problems.

A second barrier is the threat of malpractice litigation in our medical professional liability system. Experts again tell us that by punishing those who make mistakes the system favors covering up errors rather than taking active steps to try to uncover errors and learn from them.

The paper describes a number of recent national initiatives that have been undertaken to address the problem of errors systematically. I won't review them here again individually, but as I said they're all quite new undertakings so we don't have a lot of data available at this point by which to say how successful these individual efforts have been. But I think there are a few lessons that we can take away from Medicare at this point.

One lesson is that these initiatives have provided an illustration of the notion that errors won't be reported if the reporting body has the power to punish those responsible for errors. JCAHO, or the Joint Commission on Accreditation of Health Care Organization, their sentinel event policy provided an illustration of this. The organization has made recent changes in its policy to try to address this concern.

A second lesson is that reporters of problems of errors must believe that their information is going to be held confidential or they won't feel comfortable sharing that information. Right now confidentiality standards differ by state and this presents problems for national sharing of information. Some have proposed creating national guidelines that dictate how sensitive information can be treated for quality improvement purposes.

Finally, the initiatives that have been undertaken illustrate the benefits of coordinating initiatives and trying to get at problems in multiple ways. Many current initiatives have implemented several

individual activities, trying to get at the problem of errors in slightly different ways and approach it in several ways at once.

I think a good example of this is the VA's approach. The VA has set up an awards program for health care practitioners who take steps to identify errors. They've developed an error reporting system designed to get at root cause information and to disseminate that information among others who might use it. They've developed a partnership working group with others in the public and private sectors who are interested in trying to address this problem.

Now we get to Medicare's role. I think there are several tools that Medicare could use to try to encourage or facilitate health care providers' efforts to address errors. Payment policy is obviously one powerful approach that Medicare has. This includes both coverage decisions and payment mechanisms.

Medicare's conditions of participation for its providers are another approach that can be used to get at the problem of errors. Quality improvement requirements and quality measurement public reporting measures, these are similar but not quite the same. The first of the tools is designed to set up incentives for improvement without bringing public scrutiny necessarily or comparisons among providers to bear. The second approach offers public accountability and is likely to be more controversial in that respect.

Now we'll move on to the specific issue of autopsies. This is one area where it might make sense for Medicare to focus its attention. Autopsies are a unique service in that they aren't undertaken for the medical benefit of a particular patient. Much has been written about the wide range of benefits from autopsies, including identifying errors in diagnoses -- and we know that these types of errors still occur in anywhere from a third up to half the time.

Providing control is another benefit. Contributing to the knowledge base of individual physicians and the medical profession as a whole. Improving accuracy of public health statistics comes about due to the fact that autopsies often uncover reportable diseases that weren't otherwise found.

So virtually everything out there tells us that autopsies are a good thing for public health and for health quality. But still we see that rates in hospital provisions of autopsies have fallen dramatically. We don't have one good source of national reliable statistics on this, but we do have surveys, accreditation reports, and local studies that have consistently found that autopsy rates are right now in the range of about 5 percent for community hospitals and about 10 percent for teaching hospitals. This is quite a dramatic drop from the previous rate of about 50 percent in the 1960s.

Experts have put forward a number of reasons why autopsy use is down and these theories have been supported further by surveys of providers. Perhaps the key reason for autopsy use declining, two key reasons, the first being the fact that many insurers don't pay for autopsies directly or at all. Medicare pays only indirectly for autopsies through it's prospective payment system for hospitals, which means that hospitals and physicians have financial incentives to minimize rather than to maximize the number of autopsies they provide, just from the financial perspective.

The second reason relates to industry standards. Both Medicare and the Joint Commission on Hospital Accreditation currently does not require a set percentage of autopsies to be performed, although they did have such standards in the past.

A third concern learning to the decline in autopsy use is believed to be the fear of litigation. Some experts again have said that this is actually unfounded in that autopsies often provide information that can be useful in defending against malpractice suits that are unfounded.

A fourth reason is that some have said that technological advancements in diagnostic abilities have rendered autopsies no longer as useful as they were in the past. Again, there are some research findings that suggest that that's not, in fact, true and that diagnostic accuracy remains the same as it has been. But nevertheless, if that's the belief, then that's still a cause for decline in autopsy use.

The final two reasons cited for autopsy decline would be societal discomfort with death. And that leads to people refusing to provide permission for autopsies, as well as doctors' discomfort in talking about it.

Finally, supply issues. It's believed that pathologists are now spending more time doing other types of activities. And furthermore, certain hospitals may no longer have in-house capacity to undertake autopsies.

There are two, I think, key reasons why Medicare seems well positioned to look at this issue of autopsies. The first is that Medicare beneficiaries account for approximately three-quarters of in-hospital deaths. The second is that Medicare has traditionally played a role in funding health costs that are believed to be a public benefit generally, even when they're not beneficial to individual patients. Obviously, graduate medical education is one example of this type of role.

Even those people who do think that Medicare should take steps to address autopsies, however, are not in agreement on what policy options are the right ones to pursue, however. The paper lays out six potential options for pursuing Medicare changes in autopsies that have been put forward.

The first one is changing conditions of participation. This would change Medicare's conditions to actually require a set percentage of autopsies. The drawback to this change mainly is that we don't know what the right percentage is. This is one of the main reasons why this standard was changed in the past. If we were to implement this kind of change in the conditions of participation, we'd probably want to

have more flexibility to allow for different standards where those were appropriate because lack of flexibility was one problem in the past, also.

The second approach for changing Medicare's policy would be to change payment. The obvious change that's been put forward is to cover autopsies under Part B, thereby directly reimbursing individual physicians for autopsy coverage and providing them with individual incentives to perform the service. But this would be quite a change in that the services themselves aren't provided again for an individual patient so it would make it quite a unique service on the fee schedule.

A third option might be for HCFA to work with the hospital industry to identify regional centers for autopsy provision. This might make sense in terms of efficiency and it would maximize perhaps the benefits of autopsy provision if it were correctly structured. On the other hand, some argue that autopsy provision should be a key part of every hospital's activities for quality control and to educate the physicians in that hospital.

The next two options would focus on making appropriate autopsy use a quality improvement focus for providers. HCFA's quality improvement organizations might be directed to make autopsy use one of their priorities for improvement, but it's not really clear that QIOs have the leverage that they might need to overcome some of the root causes for decline in autopsy use that we've seen.

Alternatively, HCFA might collect information on autopsy performance measures and report that to create public accountability. We don't have good autopsy measures right now, although there are some steps being undertaken to try to develop those measures. So this might be an option for the future.

A final approach would be to engage in a public education campaign to try to inform the public about autopsy use and to incite some demand.

So in conclusion, I'd like to kind of lay out three possibilities for next steps in this area. In addition to hearing from you on these issues, I'd like to get some feedback in terms of which direction -- I guess you could go in more than one direction -- but which way you want to proceed on this topic.

One approach would be to move toward recommendations on the problem of errors generally in Medicare, whether Medicare should take specific steps such as developing an error reporting system or something else. A second approach might be to examine the autopsy issue in greater death, moving toward recommendations on Medicare's autopsy policy.

Then a third approach might be to look in an in-depth way at some other areas in which Medicare might have an opportunity to make a difference. Medication errors is one possible area, nosocomial infections being another, and there might be others that you're interested in.

DR. CURRERI: I want to address two areas. The first is obstacles to addressing the error, of which you've listed two. I think there's a third, and more important one, than either of those two. That is the attitude of certain insurance companies that handle professional liability.

Not all, but many threaten to either increase premiums inordinately if you have a successful suit against you or withdraw from a state entirely if there's a bad experience there, particularly with juries that are overly responsive to plaintiffs in terms of dollar settlements.

And frequently, some of these companies take the attitude that they will fight any suit, no matter how obvious the error was. That brings into play a number of defense lawyers whose whole purpose is to hide any errors, if possible.

So I think that you need to put that influence in there as a very important influence.

I think you also ought to look at, besides examples you gave, of many of the university consortiums who have, either on a state-wide basis or regional basis -- self-insured. Because I think, for the

most part, they've taken the absolute opposite tack that it's much less expensive to admit an error and immediately go to the patient and arrange a settlement rather than to let it go on for two or three years while hostilities build up and the price goes up, to settle that. And also, they've taken the attitude that the more errors they can identify the more preventive actions they can take to prevent those errors.

That's a totally different attitude, much like the VA has taken, and those might be good areas to look at. There are several around the country that I can tell you about if you're interested.

I also want to make a comment about autopsies. It is true that the autopsy rate in the 1960s was about 50 percent. It's also true there were very few malpractice liability suits at that time. In fact, it was almost unheard of. But I really don't think that that's been the major reason for the decrease in the autopsy rate.

I think that, for those of you that are not physicians, the hardest thing that a physician ever does is to request an autopsy because you've just been dealing with a patient that you've had an intimate relationship with. You've been dealing with a family that's been going through a very tough time. And now the patient dies and no longer owns his own body, and now you're asking the next of kin to have another procedure done.

The obvious response in many ways, sometimes due to guilt, is that well, grandfather's already suffered too much and I don't want him to suffer anymore. No matter how unreasonable that sounds after he's dead, that's the way most people feel.

The reason there was a 50 percent autopsy rate, in my opinion, in the 1960s was the JCAH requirements to have a certain autopsy rate so that there was a lot at stake if you didn't do it. So you did an unpleasant job.

When JCAH dropped that, nobody wanted to do that job of asking for an autopsy. And unless you were trying to get an organ for transplant, that is a patient who wasn't diseased, wasn't too old, was a

trauma victim or something of that sort, it was very easy to drop the enthusiasm for asking. I think that's probably the most important factor.

I don't think educating the public is a very rewarding way to go. The reason I think that is because it hasn't been very rewarding from the standpoint of getting organs for organ transplant, either. It's something that should be done, but I think it's a low reward program and I really think the only way you're going to get back to that again is to put teeth into some minimum autopsy rate, and that will give the hospital directors the teeth to go ahead and request of their attending staff to get autopsies.

DR. MYERS: I want to comment on the same issues. First on the issue of the autopsy, I think Bill is right. Even when I was a medical student, we did a hell of a lot more autopsies than are being done today. I'm not sure of all of the reasons why they've dropped, but I think that we've got to do something to reverse it.

I didn't realize, first of all, that Medicare didn't pay directly for them. That was something that I just learned from you. Secondly, that the rates have fallen off so significantly.

I think that there are a lot of people who could give us good advice on this issue, specifically the medical and the hospital association, and more specifically the pathologists could probably give us some very good advice on how to target it, whether regional centers would or would not be effective, et cetera. I think we ought to take advantage of that expertise as we move forward.

But I also think that we need to conclude that there should be some recommendation to use the payment policy to facilitate an increase in the number of autopsies, whether it's mandated through a specific vehicle or not. I think that that's absolutely the right way to go, with respect to learning more about possible errors that occur during care.

I would agree that educating the public on this issue is probably not my first choice nor my second or third. It's going to be very difficult for the public to understand, and I'm not sure that -- people are going to be so rarely in the position that they make that decision that a general education effort will probably not provide us any specific opportunity to improve that rate and it will cost money and will probably cause more trouble than it would if we did it the way I've already suggested.

I think the liability issue is a significant issue that needs to be factored in, as well.

I want to switch gears and talk more about medication errors, because I think that's where there's a huge opportunity. There's a lot that's been done on that in the last few years. I'll just give you one example and there probably are several others that are equally advantageous for us to look at.

I know at the Petersburg Brigham Hospital, they've been using a computerized order entry system for the last several years. When a physician orders medication there is a database there that has information about the patient's allergies, what other medications the patient is on, height, weight, and those kinds of factors that are used in order to judge whether there's an incompatibility within drugs, whether the dose is proper, et cetera. So when a physician inputs an order that's incompatible, before the order entry system allows that order to be processed it will query the physician did she or he know that XYZ was true or that the patient was already on ABC.

They've learned from the query system that physicians often, in the rush, can forget about some of those very important factors. And the system has proven effective in reducing substantially the kinds of orders that would result in a significant adverse medication event.

I know a number of hospitals, including several I'm affiliated with, are now looking to bring that kind of system into their facility because they believe that these systems are the wave of the future and, with respect to inpatient medication errors, offer significant protections that do not exist today.

I don't know whether the hospital association has reviewed them or has taken a look at them or has an opinion on them. But I think, from everything that I've learned about them, that they are absolutely a positive asset to reducing the number of errors. And I would think that we might want to explore that and make recommendations along those lines to motivate, encourage, push, whatever the right approach might be, using the Medicare program to facilitate these kinds of systems to be placed in the hospitals that we have to fund.

DR. KEMPER: I found the discussion of error reporting very stimulating. It seems to me worth pursuing. I guess one question I have is who's accountable for the errors? I mean, who would be in a position to use and to act on the error information?

I understand in the airline industry there's the airline and I guess the airline manufacturers. You can imagine the airline looking at all the margins for improving safety. And I can see it in a hospital. I can see it with the health plan being accountable. But I think some thought is needed to think about who's in a position to really reduce the errors and how that works in a Medicare fee-for-service program.

I guess the flip side of that is I think it would be useful to broaden the sources of errors. Maybe that's implicit here, but there are equipment errors, there are pharmacist errors as Woody mentioned, patient errors, nursing errors. There are all kinds of errors that occur in health care and how to get a broader perspective on that.

I guess the third thing is a question about the quality work more generally and whether or not there's some work planned monitoring what HCFA is doing and fee-for-service quality improvement and looking at other efforts, in addition to the error reporting. Have you thought about other things?

MS. DOCTEUR: Yes, I started that work and you'll see it at the next meeting devoted to the June report.

DR. KEMPER: So this is just a piece of that?

MS. DOCTEUR: This is just envisioned, depending on your feedback now which for the most part sounds like there's some interest in this, this would be envisioned that error reporting would be one chapter in the June report. Then a second chapter would be a broader chapter on quality assurance under fee-for-service, looking at all the different types of things that are going on.

DR. KEMPER: Great.

DR. LAVE: Robert Wood Johnson has funded a couple of projects to look at the error issue, and you may want to just check with who they're doing and where they are. It's under health policy.

DR. LEWERS: I just wanted to point out that the National Patient Safety Foundation, which you've highlighted, is having its second Annenberg conference soon. I've forgotten the exact date. That's oversold. So there's a great deal of interest in this and this is something that I think is very appropriate and very timely.

I think one of the very key elements is the punitive issue. It's got to be a learning opportunity, not a punitive issue. I think we've learned that in raising our children. We all make mistakes. They make mistakes. And we no longer use the same basic approach to the children as we once did.

I think we have to be careful, and we were just talking a minute ago about can we find another word for error. We've been wordsmithing today. Learning opportunity, misadventure.

I was going to make the point that Woody made about the ordering of drugs, et cetera. And in an adverse drug reaction, if I order someone ampicillin and they get a skin reaction or they have the diarrhea side effect from that, there's no way I can safely -- except if I know they don't have an allergy to penicillin -- predict that. Nosocomial infections, I mean, these are listed in several of the studies you talk about as errors. And indeed, they're not errors.

We have to be very careful in our definition. I think there should be an explanatory section on what are really true errors and what aren't.

For instance, alternative medicine is becoming a lot more population now. Patients come in and they're afraid to mention to the physician that they're using an alternative form of therapy and you prescribe something and they get a reaction. Is that an error?

I'm glad to hear you talk about the liability issue, Beth, because quite frankly, having a little bit to do with liability, we would prefer to have an autopsy. If I take a case to court, I have a much better chance of winning that case if I have an opportunity to know what's going on.

And most companies, and Bill, I don't agree with your assessment of some of the industry, there may be companies that do that but I think there are very few in today's world that don't want an autopsy. They would prefer to have them. It really does help in most of the instances.

But if we talk about autopsies, I think that Bill's hit upon the point with JCAHO and a percentage. And physicians do have a hard time talking about it, but we talked about it back in the '60s so we can talk about it now.

But physicians also think well, I've got the MRI, I see the whole body, I can turn it upside down, I can computerize and rip it around. That may show us a lot of things, but if you see an adrenal adenoma and you missed it, that doesn't mean that that had any relationship to the patient's illness or the patient's death. The same thing with a lot of other factors we see.

And yet in the statistics that you're talking about, many of those were classified as errors because they weren't known but didn't have anything to do with it.

The other factor, and I think the key factor is cost, because they can cost $2,500. A lot of that is the pathologist has got a major portion and it takes a lot of time to do this sort of thing. So we're going to

have to find some way of basically either reducing that cost or in some way covering that cost. But I don't think regional centers are the answer.

If I were to ask a patient for an autopsy and say well, I've got to send this patient to Wilmington, Delaware because that's the regional center, they see that as a delay in what they're having to do with their services. In certain areas it is a delay. And so I don't see regional centers as a viable alternative unless we deal with a lot of centers, I mean a lot of regional areas.

So I think this is an excellent chapter. I'm glad to see it's here. I think it's something that we need to address but we have to do it with great care so that we do cover all of the issues we've heard around the table and the ones that I pointed out. Thanks.

MR. SHEA: I think the literature seems to be clear that if you're going to address errors in any field, then you need to create a safe situation for that to take place. It includes, certainly, addressing the liability issue in this field in a way, I think, much more aggressively than has been done.

But I wanted to raise the adverse event issue. It goes to a different, and possibly somewhat conflicting dimension. What happens now when there's an adverse event, death or dismemberment or something, in terms of HCFA's rule? What do they do? Do they, first of all, require that it be reported? And do they do something if it is reported? Or do they just rely on the JCAHO process?

MS. DOCTEUR: They rely on the JCAHO process to my knowledge. The QIOs, the Quality Improvement Organizations, do play a role in investigating both patient complaints about situations, which adverse events might be one, any kind of quality concerns. The QIOs then report to HCFA on the outcomes of their findings. Then it's up to HCFA to take any kind of action based on those findings if they feel that they want to.

But my understanding is that the QIOs role has really changed quite a bit in the last few years and that HCFA is really downplaying this sort of policing activity and leaving it more to the industry and the providers themselves, to police themselves.

MR. SHEA: I think this is something that needs to be explored further than your paper does because, in terms of the interest here, on the one hand we think we can see in some other fields -- whether it be aviation or some of the individual things like pharmaceutical errors -- how these could be addressed in non-punitive kind of ways.

But the other side of the coin here is I don't think there is very little awareness that errors that lead to significant adverse events could occur in hospitals, and that there is no even public recording of those that are necessary, never mind sort of an investigation. The JCAHO process is a voluntary process for the reasons that we were just talking about.

I don't think that you can just look at one side of this situation. I think you need to look at both sides. I think from the consumer point of view, people are interested in knowing that if there's been a major problem, or even worse a series of problems, at a particular facility or in a particular plan, that they're going to somehow know about that.

I mean, I think people would say of course, that's automatic, right? Most people just don't know that there's not a process like this. In some states there's reporting, but it's a very complicated area. I think you need to do more on the other side of this, though, which is what role is there for either reporting or both reporting and investigating serious incidents?

DR. NEWHOUSE: I was going to say some things along the lines Gerry just said. First, I liked the chapter. I liked all your options at the end, focus on reporting the autopsy case and adverse drug events and nosocomial infections.

My understanding is similar to Gerry's on the reporting system, that in several states the reporting cannot be shielded from plaintiff's attorneys, so that reporting basically fails. Now we could lay that out, and I don't know what options HCFA, Medicare and the Congress has for dealing with that. But it does seem to be different than the civil aviation case.

A comment on our discussion here, having just said what I said, my reading of the literature is that this discussion is too intimately tied to professional liability and medical error and that they're related but that they're distinct topics. For one thing, a lot of the discussion focused on the physician making an error. But in fact, if you look at the error literature, for a bad event to actually be realized, there typically have to be a whole lot of people that screw up in some fashion. It's not just the physician.

In fact, one of the lessons of the air literature is look at the whole system and try to prevent error or mitigate its consequences rather than improve human performance. I think maybe you said that.

Second, in terms of Ted's comment on the definition of error, he's right up to a point but -- that is to say that there are errors in roughly -- in our old New York study, which is the one that's often cited -- about 4 percent of admissions. And only about a quarter of those are negligent. For example, if I fail to ask the patient who is allergic to penicillin and gave the patient penicillin, then that would be negligent. It would be negligent anyway in my case, since I don't have a license to practice.

[Laughter.]

DR. NEWHOUSE: But if the patient never had penicillin then it's an adverse event, there's no negligence.

The only point I would make there however is that if you think of this in a context over time, you would like to have incentives in place to reduce the incidence of or the consequences of errors that would not be classified as negligent and make systems basically safer over time.

I had a small picky point. On the autopsy decline and discomfort with death, absent any evidence that people are more uncomfortable with death now than they were 30 years ago, it wasn't clear to me why discomfort with death could explain the decline.

DR. CURRERI: Because doctors don't ask for it.

DR. NEWHOUSE: I buy your story about we dropped the requirement and I think that it may be worth trying to explore a requirement in Medicare. Now that would mean we would have to presumably pay for it because it's only built into the DRG to the extent that the current level is there.

I was going to suggest that one of the things I would like to know would be what various levels of autopsy would cost, which wasn't here. I would think before it actually happened, we -- or whoever was advocating this -- would have to come up with a cost estimate.

I, finally, was a little surprised at Woody that he didn't say that quality was job one.

[Laughter.]

MS. NEWPORT: I guess several people have referenced this and I think it all goes to what shoes that an entity, like a hospital -- self-reporting goes to mitigation and it is taken as a well-meaning effort to address a process problem or whatever it is, whether it's with an individual patient or it's a system that the hospital has improved.

I think anecdotally I've heard, too, that right now HCFA thinks that self-reporting is basically -- you don't get any consideration or credit. I don't know what that would mean exactly, but for addressing something proactively and trying to make sure that it doesn't happen again.

And I think that's at the heart of this in one level, is there's no reward or disincentive to act appropriately or is there some reward for making sure that the situations are corrected in the future? So it's a mitigation standard and fraud and abuse, et cetera.

So there seems to be some thematic interest in that type of thing right now.

DR. WILENSKY: I had a comment, Beth, about trying to do a slightly better balance in terms of the chapter of examples of how we could reduce error. I think the autopsy example is a good one. I know Joe has been interested in this. And it has the probable appeal that it is not likely to be extraordinarily expensive, especially if we think of a sampling rate for lots of reasons, I don't know, somewhere between 20 and 50 percent or 20 and 40 percent.

I think it would be useful to have an estimate about what it would cost for Part A and Part B expenditures if we were to make some compensation and whether or not both parts were, in fact, required. Certainly B is required because there isn't a direct physician, and probably something with regard to A.

And then the further discussions about using it as either a condition of participation or an accreditation. It really does seem to me that the number one reason is that JCAHO dropped it and then, secondly, there isn't direct reimbursement. But it's probably in that order, in terms of what's going on.

But I think the fact is that we really need to think about these, as you indicated in your workplan, as one of several examples. The adverse drug response is something that has gotten a fair amount of attention in the sort of quasi-public journals because of some spectacular mistakes that have occurred and also because of some reports that got picked up by the popular press about the numbers of errors and the ramifications, in terms of hospital costs or other measured health care costs that adverse drug reactions have been associated with.

The problem, as I was talking with both the men on my right and my left is it is likely to be much more expensive to try to respond to put in systems to respond. And that's why I think it would be interesting to have a couple of these examples, some of which may be much more immediately feasible. Others, like the adverse drug, which may ultimately be even more important, much more expensive, have to

occur over time and have some pieces which are already required by HCFA with regard to some of the drug utilization, information that's required. But what it would take to make say a series of sequential steps.

To get to the issue that Janet and Ted, and Woody to a lesser extent, had raised about the tension between punitive response and self-reporting, it seems to me that there has been a substantial increase -- I don't know about substantial. But there's been an increase of reporting with regard to fraud and abuse and the assumption that if you don't get credit, you may at least get treated a little more gently. If a hospital or a health care organization stumbles on an inappropriate billing practice, it strikes me that there has been much more -- because of instances that I've heard about -- about institutions or plans that self report and then indicate the kind of steps that they have taken to change the process that allowed for this error to occur.

And that having some similar environment that was supportive at least of saying this is what we have found and this is the process that encouraged it and this is the kind of process re-engineering that has been put in place to try to prevent this from happening.

But I guess it would be curious to have whatever insight you can on the liability issue and some of these other organizations. You know, airlines have been noted several times as being good models for focus on systems, self-reporting. But they certainly have lots of liability challenges after one of their errors slip through in the form of an airline crash. And how have they dealt with this tension between concern about punitive and appropriate concern raised by Gerry and Joe.

DR. NEWHOUSE: The reporting is on near misses so there was no liability. The crash everybody knows about, you don't have to report it.

DR. WILENSKY: So you don't really have anything that is comparable.

MR. SHEA: I think what there is is they're parallel systems. There's a voluntary near miss, the not adverse outcome, which is through this NASA-based system. And then there's the required report of an

accident of some kind, maybe with or without injury, but certainly with injury which goes to the FAA, which is regulatory. And then they do an investigation.

DR. WILENSKY: But one of the problems I think that you get into with medicine is the accidents are less obvious. So if you don't have some allowance for showing what you have done to make sure that this is unlikely or less likely to occur again, your incentives to not report and let them find you, so to speak, are rather strong. But this is clearly to the detriment of public good.

I think to the extent that if there's anything that you could find that would shed some light on how to try to balance, other than say thou shalt.

DR. NEWHOUSE: You can imagine a near-miss system in, for example, adverse drug events where the nurse caught a mistake.

DR. WILENSKY: I understand that. I'm responding more to the concern that was raised about self-reporting problems that had adverse outcomes in situations in which there's a reasonable likelihood that the system or the institution may stumble on the fact they have a problem, but it is not going to be in their interest to report it if it was going to be associated with liability which doesn't prevent the institution from correcting it but prevents every other institution that may be doing the same thing from knowing about it, and therefore having to reinvent it.

To the extent that there's anything that you could offer in the next round, I think it would be helpful.

DR. CURRERI: I just want to point out. We've talked about autopsies and we've talked about pharmaceutical adverse events and a variety of other things which may have potentially expensive solutions. But I would point out that if you have a good reporting system, and the one I'm familiar with is

where the hospital and the university physicians are all self-insured by the same entity, you find some very interesting injuries that are easy to correct.

Like for one three month period by far the greatest repeating injury was people falling out of bed. It wasn't the nurses' fault, it wasn't the doctors's fault, it was all their fault. The doctors left the bed rails down, the patient requested the bed rails down, the relatives leaned over to give them a hug and left the left the bed rails down. The nurse got called to another emergency and left the bed rails down.

And once you recognized that problem, which none of us were aware of because we'd maybe only been involved in one or no cases, it was very inexpensive and very cheap to correct that overnight.

DR. NEWHOUSE: A similar analysis of oxygen deprivation in the OR where people installed an alarm bell every time the oxygen shut off and it stopped it.

MR. JOHNSON: While we've been sort of talking with an institutional focus, I know the other place we need to watch with this population for drug maloccurrence is not in the institution but when they go to the pharmacist to full their prescriptions. I know with my mother and mother-in-law usually once every two or three years the pharmacist will say gee, you shouldn't be taking this with that.

I know the Blue Cross system in Michigan is imbedding into their pharmaceutical payment system an alarm that will alert the pharmacist when something has been prescribed that this patient shouldn't take with something else because of a potential interaction or reaction.

So we shouldn't lose sight of this population is actually getting most of its prescriptions outside an institution, not in the institution.

DR. WILENSKY: It's a little tricky there because Medicare doesn't cover it.

MR. JOHNSON: I know. I'm just following where the problems are. But from a health plan point of view, and also from a purchaser point of view, I'd like to hear comments about requiring payment

on the autopsies and so forth. What happens if we have an older person enrolled in one of the HMOs, and so on?

MS. NEWPORT: I guess part of that, if Medicare covers it, one assumes that there'd be some sort of pass-through, but in the short-term if that isn't covered then there would have to be some kind of negotiated payment with the facility.

MR. JOHNSON: Of course, the other thing we have is the transference of good habits. You know, sometimes it's from the private sector to the public sector and sometimes it's from the public sector to the private sector.

But let's take this one. Again, with purchasers and health plans, if Medicare started covering this, is this the kind of thing we ought to be doing for Medicaid, private insurance?

DR. MYERS: It's an excellent point and frankly I don't know. I don't know whether we cover those or not. I guarantee you when I get back, we will move on that. Because I really do think it's an important issue.

When we do the cost analysis we ought to not just look at the outlay but potential savings as well because if we start recognizing more and more problems that we can anticipate, then there will obviously be some longer term savings to it. But that's a very good point and I think that it shouldn't be just Medicare, it should be everybody.

MR. JOHNSON: Then the question will be, who's going to write the New England Journal of Medicine article that says we ought to start autopsies again?

DR. NEWHOUSE: The JAMA editor has been on a crusade for several years to do this, so they'd be the proponent.

MR. MacBAIN: I think in terms of coverage for any insurance company that operates on a claim based system, any claim submitted for anything that happens after the date of death isn't going to get paid because that point the person isn't a member. So in all likelihood, most claim based systems won't.

Medicare, I assume, used to pay for it when hospital reimbursement was on a cost based system. The move to DRGs, probably coupled with the change in the then-JCAH requirements, probably both happened about the same time and knocked the pins out from under it.

I want to go back to something that Bill Curreri said earlier, of looking at the effects of a system of voluntarily reporting maladventures, negotiating settlements with families, and learning from the consequences. I think there's a lot to be learned from that, getting over the instinctive defensive reaction.

Related to that, I think there's a lot in the broader quality improvement literature about focusing on process rather than individual error that is very constructive. You begin to get beyond finding out whose fault it was and say if the system was designed properly it wouldn't have happened because you wouldn't have done things the way you did them, it's not your fault, let's go back and fix the system.

It's not only a less threatening environment, it actually improves things. It improves things beyond changing one person's behavior to having an effect institution-wide such as the issue of bed rails.

The third thing is just a point of clarification. In the narrative, the discussion of misdiagnoses suggests, when you read it the first time through, that there's been no improvement in the accuracy of diagnoses over the last 60 years, which I suspect is not true. That people in 1938 died of illnesses that today are diagnosed actively and treated effectively. People die of different things now, things that perhaps can't be diagnosed without an autopsy or things that are different from the diagnoses that are learned on autopsy.

I don't think it's a comparable population in that sense.

DR. LEWERS: Just along the same line. If we look at encounter data and look at the number of encounters with patients per day, the system is still a very safe system. We can't accept the errors that we're seeing, we can reduce them.

But one of the things, too, that we've got to be careful in comparing the airlines because they're comparing miles flown. So we've got to talk about the number of people that we are seeing.

So the point is, again, it's back somewhat to definitions, as to where we really are going with this system.

MR. MacBAIN: To just follow up very quickly. I guess the last thing with this analogy with airlines is that somewhere it's pointed out that the pilot of an airliner has got enormous backup systems to prevent error. So there's really nothing comparable in medicine, and yet medicine is a much more complex process. We might look at that as well, in what sorts of lessons are there in other industries that provide additional information, warnings, the alarm bell kind of things to augment individual decisionmaking?

DR. LAVE: I want to come back to the autopsy issue and to sort of indicate, we have in a lot of these things a lot of mights and maybe should and that kind of stuff. And if we want to, and there seems to be a feeling about this, increase the rate of autopsies, shouldn't there be some direction given about the types of autopsies and the types of cases of autopsies that one would like to see done?

I mean, one of the things that always puzzled me is that I was once in a debate on the autopsy issue. And then you would hear people talk about here I have a geriatric patient, they have thousands of different cases and diagnoses and we don't really know what killed them. And my feeling was do I really care which of 20 different diagnoses killed somebody if they're going to -- since they're all mixed up?

So as a naive person, it didn't seem to me that I cared that much. Why I should care that much about somebody with 25 different conditions, which was the specific one that did the person in? Why couldn't you just call it old age or something. It may not be very sympathetic.

So I guess I'm curious about if we want to increase the autopsy rate, my understanding is there's two reasons for doing it, one of which is to get a correct diagnosis so you know what killed the person. And the other, in the context of this, is to worry about error rates.

So I guess the question that I have is should we have some thinking about what kinds of patients should one really care about the actual cause of death? Does it make a difference? And should anything be said about that?

And then the other one, if one is talking about sort of generic error issues, is this a random sample problem issue? Is this a weighted something? I mean, can we say something other than we ought to increase the autopsy rate?

DR. CURRERI: I think a lot of states already do that. For instance, many states --

DR. NEWHOUSE: Do what? A lot of states do what?

DR. CURRERI: A lot of states already set priorities for who gets autopsies. For instance, most states will say that anybody involved in an accident, it's a mandatory autopsy. Most states will say that anybody that died without any physician ever seeing them requires an autopsy.

Then you get down to the two points you were getting at, and I think those are, for the most part, what you're going to learn from an autopsy is a misdiagnosis or an error of an operative technique of one sort or another. But I think those are important because if you have an failure of an operative technique, you best know about it so that you might improve whatever it is you were doing to make it better so that it will hold up in the future.

I would agree with you, there are probably some patients where we learn very little and there might be less emphasis on that.

I think it's very hard to regulate those things, too, because there's so many grays.

DR. LAVE: I was just curious about whether we can give some suggestions or some ways other than mandatory -- we have a lot in here about the desire of increasing autopsies and very little to say what kind of autopsies do we want to have increased. And I think that it's only responsible to say something about what kind of autopsies you would like to have increased.

MS. DOCTEUR: Let me just add, Medicare has some very general standards. They specify that you're required to seek an autopsy in cases of, I think, medical educational interest, legal interest, I have the feeling there was a third one but I can't think of what it was offhand. But then they also require that individual hospitals set up their own more detailed criteria for determining that. But they leave it up to the profession and the individual hospitals.

DR. LEWERS: Along the lines what Bill's saying. I'm not sure there are many states that require it. They require that you report it to the medical examiner or coroner, whatever the case may be, and that individual has the right to decide whether or not they're going to have it. And many of those individuals today are not doing autopsies, as well.

So I think it's a broader issue than that.

DR. CURRERI: You are correct.

DR. LEWERS: I think the other point, which obviously is not -- you know, it's a very sensitive issue with physicians, is that the rhetoric that we see in many of these cases is not helping us at all. We're seeing a lot of very blanket statements, like on the 60 Minutes show when it was said that doctors are burying their mistakes. I mean, those things don't help.

So I think we have to face this realistically and try to approach it, as I think we're doing here. I think that's the approach that needs to come out of that, and not some sensationalizing that has been done.

DR. WILENSKY: Any further comments? I think you have probably more guidance than you need.

DR. LEWERS: I hope you don't have anything else to do for a while.

DR. WILENSKY: Let me open this to public discussion on any of the issues that were raised this afternoon.

DR. CASEY: Dr. Casey from the Maryland-DC QIO, and I appreciate that designation, as opposed to the PRO. I want to talk about the PRO's involvement, or the QIO's involvement in this activity but I want to make a couple of comments first of all.

One is to the Commissioners, the discussion has really been revolving around the inpatient setting implicitly, and I would challenge you to think of all domains of care with respect to the error issue because I think it's a much greater problem outside the walls.

Dr. Lewers had talked about an issue related to classification involving errors. It's really, I think, more of an art than a science at this point. Some of the issues revolve around, for example, designating systematic versus non-systematic or random errors. And also errors of commission as opposed to omission. These are some examples of how perhaps an error evaluation system could be put into place.

For those of you who are familiar with Leip's articles in the New England Journal with Trian Brennan in the early part of the decade, it underscores the issue of art versus science in the sense that most of the statistical analyses evolved around using weighted CAPA, which is rate of reliability, which was assumed to be de facto standard of care.

I think there's some caution in making that assumption, but the Commissioners might consider reviewing Leip and Brennan's articles if they want more detail, if they haven't already.

With respect to autopsies, I agree with the other physicians. I have the same experience as a practicing physician and I would suggest that errors resulting in death are potentially beneficial for unexpected deaths. But most of the deaths that occur now in the hospital, by and large, are expected in the sense that patients come in in terminally ill states or have had long stays in intensive care units.

So perhaps looking at unexpected deaths with autopsies would be useful, but I'm not sure that autopsies add additional information. Most of the determinations of error can usually be done by other methods or are obvious even before the autopsy is done. So I would suggest an analysis of sensitivity of autopsies in picking up errors. I expect that they would be low.

Getting to what I stood up to talk about, and that is QIOs, the past activities have been in the late '80s, involving random chart audits, looking for outliers with the goal of applying punitive measures, or at least the receiving end looking at these as punitive. And we've moved away from that, but we still have contractual obligation, as Dr. Wilensky knows, to sort out other issues that might come about as a part of our quality improvement activities.

As it turns out, the self-reporting part of this has actually been useful. We've taken a show versus a tell approach to this by giving hospitals, for example, their outlier cases. And we've found the receivers of this to be actually grateful. Some of them have fed back to us that they've taken the information and looked at it and found some issues related to errors. So I think that it gets into this punitive nature business.

I think there's a right way and a wrong way, and most places have an internal mechanism for looking at errors, but again it's largely subjective. And that's where discussion of errors takes place first, at the local levels. So if there's a way to systematize that, I think it would be more beneficial.

DR. WILENSKY: Thank you.

MS. COYLE: Just quickly on the last issue around the issue of errors. One that's obviously very important, I think, in terms of more autopsies, there may be some valuable learning there. I think the fact remains that it can still only be performed if ordered by a physician and consented to by the family, which makes it difficult.

Dr. Myers, on your point, there is I think a very fruitful area around medication errors. We have been engaged in looking at issues around best practices and disseminating best practice information. If it's all right, I'll share that with MedPAC staff. There might be some helpful information there to begin to look perhaps beyond the autopsy issue at some other process kinds of things doing on.

On the earlier topic of Medicare choice and beneficiary choice, I think we sent to members of the Commission in the spring some issues around health plan choice and decisionmaking. It was some testimony, I think, Dr. Lewers that you were engaged in along with Dick Davidson.

Just a reminder that I think there was some terrific learning from the President's Commission on Quality around how consumers make their choices. We've also got some additional learning that I'd be happy to share with staff as well around informed decisionmaking. I think one of the things that we learned is there are different variables involved in making a health plan choice versus making a clinical care choice, and staff may want to consider those different variables as they make some suggestions for the Medicare population.

But there is some good learning and I'll share that with the Commission.

DR. WILENSKY: Thank you.

If there are no other comments, the commissioners will reconvene at 7:00 p.m.

[Whereupon, at 4:32 p.m., the meeting recessed, to reconvene at 9:00 a.m., Tuesday, November 24, 1998.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Embassy Suites
1250 22nd Street, N.W.
Washington, D.C.
Tuesday, November 24, 1998

The meeting in the above-entitled matter convened, pursuant to notice at 9:08 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair

JOSEPH P. NEWHOUSE, Ph.D., Vice Chair

P. WILLIAM CURRERI, M.D.

ANNE JACKSON

SPENCER JOHNSON

PETER KEMPER, Ph.D.

JUDITH LAVE, Ph.D.

DONALD THEODORE LEWERS, M.D.

WILLIAM A. MacBAIN

WOODROW A. MYERS, M.D.

JANET G. NEWPORT

ALICE ROSENBLATT

JOHN W. ROWE, M.D.

GERALD M. SHEA

C O N T E N T S

P R O C E E D I N G S

DR. WILENSKY: We're ready to start. It appears that there's somewhat more public interest in terms of this morning's session than addressing health care errors and informing consumer choice, so we're glad to see that we have our crowd back.

This morning's session is initially focusing on graduate medical education, on physician workforce issues. As we have indicated before, in each of the meetings that we have between now and June we will be devoting some time to the issue of graduate medical education to help us get ready for any recommendations or discussions of policy issues to be included in the report to Congress in August. Let me turn this over to Craig. I assume you're going to start the discussion and then Janet, Deborah, and Susanne as appropriate. Thank you.

MR. LISK: Good morning. The information for today's discussion is in Tab H of your briefing book from the mailing material, and also the slides were passed out as well. Now Congress for the Balanced Budget Act required us to do a report on graduate medical education and teaching hospitals.

In this report on graduate medical education study we were required explicitly to consider changes in federal policies related to international medical school graduates and methods for promoting an appropriate number and mix and geographic distribution of physicians or health care personnel more broadly. So today's discussion will focus on physician workforce issues.

The next meeting we will be talking some about nursing and allied health professions workforce issues as well as potentially some other information related to the changing market -- possible space in producing these services.

Now these physician workforce issues are all interrelated in many ways, so today we're going to go through supply, specialty mix, international medical graduates, and geographic distribution. All these

workforce issues are interrelated. So what we're going to do today is go through each of these issues, providing you some background information, and then leave time for discussion at the end.

Now one important aspect though to remember is the Commission's mandate is not to determine what the right supply or specialty mix is. It is to recommend on a broader level whether federal policies should be changed to promote an appropriate supply and specialty mix of physicians. As we consider these workforce issues there are two broad questions we'd like you to consider as we're discussing these things.

First, what biases, if any, exist in the payment, the education, and the financing system that might lead to an inappropriate supply, specialty mix, or geographic distribution of physicians?

And second, at what level should Medicare or the federal government become involved in policies that influence the physician workforce?

So more specific considerations, such as how many physicians should be changed or what is the most appropriate specialty mix may be imbedded in the broader questions, so you may want to touch on them, but it is not necessarily to reach precise conclusions about those. But what we want is a direction in terms of if you think that there is an imbalance and where policy maybe should go, or where the Commission wants to go, in what direction do you want to pursue on these issues.

So to summarize in terms of the areas that we're going to be covering again and who's going to be doing those discussions, on supply Deborah Walter will be supplying some information on that. On specialty mix, both Deborah and Susanne will also be presenting information there as well, and Susanne will also be presenting information on international medical school graduates. Then Janet will close off with the information on geographic distribution of physicians and residents.

We'll come back and we'll put up this slide at the end so you can go through and make sure you cover these different areas in your discussions. But I want to leave you -- what we want is we need your

input on where we need to focus for the report on the physician workforce issues. We want you to discuss these four issues, and at the end we need the direction for how the Commission wants to proceed in terms of additional information or types of recommendations that you may want to pursue. But we're not looking for recommendations at this point in time. We're looking more or less for directions.

Also included in your briefing material is a background paper on the physician training process. That's just for your information and to provide background and to provide some context for some of the discussion on physician workforce that we're going to be discussing today. So with that I'll turn it over to Deborah and we'll proceed down all these workforce issues.

MS. WALTER: Good morning. As Craig indicated, this presentation is intended to paint a broad brush stroke of issues related to physician supply. Subsequent presentations will fill in the details on some of the issues I'm going to raise here. I will first discuss the current and projected trends in the total number of physicians. I'll then look at a few indicators to get a sense of how well the market is working to regulate physician supply. Next I'll discuss some implications of a physician oversupply, and I'll end by highlighting issues that the Commission may want to consider.

Concern that a physician oversupply is imminent has persisted for almost 20 years. Most agree that the United States has or soon will have too many physicians overall and a disproportionately high number of specialists relative to the number of primary care physicians. But what is meant by physician oversupply?

Physician supply can be viewed along a continuum from medical school to residency and finally becoming an active physician. Working backwards, this first overhead presents the number of physicians per 100,000 population. Funded by the Department of Health and Human Service, the Council on Graduate Medical Education, or more commonly referred to as COGME, has done a considerable amount of

work on the issue of physician supply. There are three important points that I would like you take away with this slide.

Number one, given the widespread consensus that the future health care system will be dominated by managed care, COGME projected that the physician requirements in the early 21st century will be approximately 145 to 185 physicians per 100,000 population. This is indicated by the red band.

Number two, in the period between 1970 and 1990, the patient care physician to population ratio increased 58 percent. COGME projected that if the numbers entering GME continued at then the current levels, the patient care of physician to population ratio will increase to 203 in the year 2000. That is, by the year 2000 it would mark the beginning of a physician oversupply, and that would be solely attributed to an excess of specialists.

And the final point that I would like you to take away from this overhead is that COGME's projections were based on certain assumptions about the health delivery system, and more importantly, based on data up until 1992. However, if we look at the current data and compare it to COGME's projections we see that a physician oversupply was actually realized sometime in the mid-1990s. That is, based on COGME's projections, the U.S. now has more physicians

per 100,000 population than is required.

Thinking along that same continuum, we also see that the output of medical schools in the U.S. has been relatively stable for well over a decade, and also the number of IMGs has leveled off after growing by more

than 20,000 between 1986 and 1993.

To get a better sense of whether the market is working to regulate physician supply I looked at three more recent market indicators, including the size of the applicant pool, underemployment or unemployment, and changes in physician income.

With respect to trends in medical schools,

since 1994 there has been a 10 percent decline in the number of first time applicants; that is, individuals who have not previously applied to medical school. Coupled with the decrease in the total number of applicants for the first time in almost a decade, one can speculate that the data are beginning to support what we have anecdotally heard for some time now; that individuals are choosing alternative careers to medicine in the wake of an impending physician oversupply.

One of the most persuasive indicators of physician oversupply is physician underemployment or unemployment.

In 1996, Safer and her colleagues examined recruitment advertisements for physicians in seven well-respected medical journals over a 10-year period. They found a decline in demand for physicians in general and for some types of physicians including internists and pediatricians.

This slide shows some work that Miller and her colleagues were doing based on graduates completing training in 1996. Specifically, Miller and her colleagues reported that 22 percent of graduates completing training experienced significant difficulty finding positions compatible with their career goals. While most resident physicians indicated that they were practicing in a location of their choice, almost one-quarter were less likely to find employment in their most preferred locations.

Even more interesting is that while the majority of resident physicians obtained clinical practice positions in their specialties or subspecialties of choice, 7 percent of all graduates who wish to enter practice reported that they had not found professional positions by the time they had completed the survey that

Miller and her colleagues had administered between May and November of 1996. Of particular note, the IMGs reported having the greatest degree of difficulty finding a position and also reported the highest rates of unemployment.

To further assess whether market forces are operating I also examined changes in physician income. Other factors being equal, in a reasonably perfect market a physician oversupply should create increased competition which in turn may drive down the price of physician services. However, as we can see from the data, the median net income for physicians across most of the specialties and certainly that I've shown up here and for a variety of others, have steadily increased between 1990 and 1996. Caution is needed, however, in drawing any specific conclusions since characteristics of medical practice and individual providers will impact direct compensation levels.

A physician surplus has obvious cost implications. Access and quality may also be affected. I'm only going to address them briefly here since my colleagues will discuss them more fully in the next three presentations.

With respect to cost, a rising supply of physicians will result in an increase in the number of services performed, and several recent analyses have projected an increase in the growth rate in the national health care expenditures over the next decade.

With respect to access, despite the abundance of physicians there has been little observable change in the distribution of physicians or improvements to access to care for individuals in underserved areas. Continued untargeted growth in the overall supply may do little to encourage physicians to migrate from oversupplied areas to underserved ones.

However, it also may be that the market is slow in responding to physician oversupply. Certainly, that almost one-quarter of the 1996 graduates were not able to practice in their preferred location

suggests that some redistribution of physicians from areas of high physician density or a trickle down effect, in other words, may be occurring.

Quality of care is also important. Oversupply may result in increased competition among physicians for patients. In an effort to maximize productivity and reduce costs physicians may have less time to spend with their patients. This may further lead to potential problems with misdiagnoses or failure to fully address patient's needs.

Alternatively, a large pool may enable physicians to spend more time with their patients and lead to more appropriate medical interventions.

In conclusion, I leave these questions for you to consider and to provide MedPAC with some direction on how best to proceed. What are the implications on health care delivery and spending of an oversupply of physicians? Is there a market that influences supply? What effect to Medicare policies have on physician oversupply? And what role should the federal government play in ensuring an appropriate supply?

I'll now turn it over to --

DR. WILENSKY: I have a lot of questions on this section. Why don't we open it up, unless most of you have an objection, because otherwise it will be too long as we go. Judy, go ahead.

DR. LAVE: A couple of things. I think it would be useful to have some historical background in here that sort of indicates how many times we thought we were going to have a physician oversupply or undersupply, what the forecasts were and how off we were. That would just be very useful to put it in context. Because I think if we had looked 20 years ago we would have said we were going to have one by today, and we don't have one.

So I think that to put it in some form of historical context to indicate how difficult it is to actually make these projections that make sense would be helpful because we've been doing this forever and we're always wrong. We've been wrong every time, I believe, that we have done it.

I looked at these applicant numbers and I guess that I'm not convinced if in fact the number of applicants increased between 1990 and 1991 and decreased a little bit in 1997 to 1998 that that's really indicative of very much. We still have a huge application for physicians.

It looks to me as if it's a very desirable occupation and what everyone wants to put into that, it would not seem to me that I would define that as sort of a decrease in the lack of attractiveness of the medical profession, given the numbers that you're showing here. So I'm not convinced that that's an appropriate interpretation.

DR. ROWE: Can I comment on that?

DR. WILENSKY: Yes, I actually -- go ahead if you want on that particular issue. I also have a comment on it.

DR. ROWE: I think that's right. I agree with Judy. I think that there may be a reduction in the number of applicants that are applying but the excess of applicants over positions that are available is probably the important quotient. It's still an extraordinarily selective procedure. I'm glad I'm not applying these days. It's very, very, very selective.

DR. LAVE: But the quality is high. I mean, the quality going up, too.

DR. ROWE: That's what I mean. I can't speak for all med schools but our impression is that the quality is not softening at all of the applicants, people who are accepted or who matriculate.

So this may be noise at a level which is well, well beyond the number that you would need to impact --

DR. WILENSKY: I think actually you might be able to even go farther. One of the things, if you want to make the statement -- I agree with Judy's and Jack's statements that it's not clear we've got much of anything here. If you want and try and see whether we've actually got something here, you at least need to look to applications to business schools and law schools because this is about the time when we also have some declines in the cohorts of people, period, in this age. So I'm not sure you're not looking at anything other than the fact that we've had some slowdown because we have fewer 15 to 30-year-olds, which has lots of impacts and probably the leading reason we've had some declines in crime.

DR. ROWE: The other thing about this, if I can just go on for one second, there was an implication that people are, or there's a feedback loop. That somebody read in the newspaper that there was a physician oversupply so therefore they decided not to apply to medical school. Students make this decision about whether they're going to be pre-med or not three or four years before they're applying, and I can't imagine they go through pre-med and read an article in the Wall Street Journal that says there are too many doctors and decide to go to law school. That just doesn't make sense to me.

DR. LAVE: And the other thing is that I think that -- I mean, again this is anecdotal, but I think and it would be interesting to look at this, that if you look at the proportion of applicants to medical school who have actually spent some time between college and medical school, that may be increasing, which is even less of an implication of feedback loop. I mention that because all my daughter's friends are all now in medical school and they clearly are older and smarter and have had time to pick up the information. So I'm just not -- I think we have to be careful about that.

DR. MYERS: We have to be more than careful.

DR. LAVE: I think the issue on location not being first choice, I'm always sort of very troubled about what to do about this. I mean, my first choice might be to be a professor at Harvard. There are

very few professions for which in fact you said to somebody, you get your first crack at something and if you don't we're going to use that as an indication that somehow or other we have an oversupply of something. I mean, it claims to me that the market may not be as tight as it once was.

But what you infer from the fact that I don't get my first choice -- and some of these people are just extraordinarily spoiled.

DR. NEWHOUSE: How many got their first choice in medical school?

DR. LAVE: Yes. I don't know how these are applied but if I think it's my God-given right to get a position in Palo Alto at $200,000 a year and I don't get this position and I say I have difficulty. I just think there's sort of a psychological discussion that goes on with respect to medical school students that we would not even think about applying to is there an oversupply of teachers, is there an oversupply of lawyers, is there an oversupply of chiropractors.

So I think we have to be very careful about what you interpret for what in the past has been a very spoiled profession. So I mean as an economist it sort of strikes me that we're looking at very strange indicators of what would be a characteristic of an oversupply. Certainly one would expect that the market would switch out. And we usually don't think of the supplier or the person in demand always having their first choice.

So I think that the issues of underemployment, underworked, and income are reasonably good indicators, more market indicators rather than some of these other things for which I think the evidence that you put in front of me is ambivalent, or I would say somewhat misleading in terms of indicators of an oversupply.

DR. MYERS: It seems to me that we should have trouble even correlating medical school graduates at all to the issue of oversupply given our policies which facilitate significant entry into the United

States of non-U.S. medical graduates to fill residency slots in our hospitals around the country, especially on the East Coast. So I'm not sure to what extent physician oversupply can and should be correlated with medical school admissions and graduation within the United States. I don't think it makes a lot of sense given the numbers of people that are entering the country that are not U.S. medical graduates and the number that are here that are not U.S. medical graduates.

So I don't understand why we're even concentrating on that. And we're going to get to that, as I understand it, in subsequent discussions.

In addition, I would like to echo the issue regarding first choice and unemployment. Unemployment as a physician is a choice. It's not a sentence. You can work taking care of patients in the United States and I think that you could work in just about any specialty. I would be very, very surprised if there's a specialty that we could truly identify where you cannot work and take good care of patients and make a very good living doing so, doing something that very important to this country and to the people that are in it.

So I don't know where these unemployment numbers are coming from or how we're defining the work unemployment.

DR. NEWHOUSE: Could I ask about that? Because unemployment at the BLS numbers is you are actively seeking a job. Is that what we mean here?

MS. WALTER: Yes, whether or not they've secured a job. A survey was done by Miller and Whitcomb for a period of over three years now. In this latest set they actually asked graduates who were training in residency programs

in 1996 whether or not they had secured employment over a period of six months is what they asked. It was from May

to --

DR. NEWHOUSE: But were they unemployed or were they residents that were looking for a job?

DR. CURRERI: Woody is absolutely correct. If you go to the rural areas you can get a job.

DR. MYERS: Absolutely. Absolutely.

DR. WILENSKY: The problem that you're in is that these are people who were presumably looking but they were only looking within certain geographic areas and were unable to secure a job. The question I think that is fair and could have some comment is if you actually look at the questions and compare it to other definitions of unemployment, to the extent it's comparable to say so, to the extent it's not comparable.

I don't actually know for BLS statistics, for example, if you say you're unemployed, you're seeking work but you're not seeking work where the work is, which is I think the bottom line, you still are unemployed. So I think you would be able in fact -- it's a point that is worth mentioning that at the same time people are saying they're unemployed, it appears there are jobs in the specialty but they are in less desirable areas. So it's unemployed but with an asterisk.

DR. MYERS: We should not equate a carpenter trying to get a job where there's no construction with a physician not having a job in an area when there's significant possibilities for a job in another area with not necessarily that much mobility.

DR. WILENSKY: But the same was true -- I mean we had during the early 1990s when Wang went out of business outside of Boston there were a lot of systems analysts and other highly educated people who were reporting themselves as unemployed who, had they been willing to move to other parts of the country, could well have sought employment. In a sense that there were pockets of high unemployment in California and in Massachusetts of highly skilled people in no way was said to not reflect unemployment in those areas.

I just think we ought to indicate, if we have better knowledge, that this is a dislocation or a mismatch between interest and availability. But to the extent it is unemployed using standard definitions I think we -- we just want to be sure we note that.

DR. MYERS: I agree with that, Gail, but the distribution of sick patients, unfortunately, is much more even than the distribution for a variety of other occupations. The point I'd like to just emphasize is that physicians can work if they'd like to work.

Then finally, the COGME estimates, with all due respect to COGME, I think medicine is changing extremely rapidly and the kinds of things that we'll be doing in medicine five and 10 years from now I hope and I believe will be very different than the kinds of things that we're doing today.

I don't know what the implications are for the supply with respect to the way that medicine will be practiced post-human genome project, given the explosion in the opportunities to take care of patients with diseases today for which we have very little effective therapy. So I would ask our fellow commissioners not to read too much into the oversupply numbers because we really don't know, as medicine evolves, what the supply issues will become.

DR. WILENSKY: Bill, if I can just interrupt, Ted had wanted to continue with this point. Then after that I have Bill MacBain, Bill Curreri, Ted if there's anything further, Joe, and myself.

DR. LEWERS: Yes, there is something further. But just on the supply, I think that we have to be careful, Woody, that we talk about physicians as physicians that have finished their training to element of training and having them go out into a rural area and practice or have an area that they can practice. As to the data that I believe you're referring to, which is the data from the AMA that was published in September of this year in which that was residents that were trying to get a position. We have tracked this over the years, and the number of residents that cannot find a position is the 7 percent number that you're referring to.

So you've got to talk apples and apples here. We're not talking about physicians who have finished training to the point that they can go out into practice, but those that are looking for that first PGY year and looking for a position there. And that is not just on location. That is actually having a physician, and overall it's 7.1 percent. If we don't have this report, we'll get you copies of this report. I think this is a very interesting report, how it's laid out.

So let's talk about what is happening. We're looking at 180,000 individuals in the pipeline right now from the beginning of medical school to the end of training programs, and that includes M.D.s-D.O.s. So we're looking at 180,000 people coming along here very quickly. So I think that there is certainly an indication that we do have an oversupply. And if we don't have it now, which I believe we do, then the data is perhaps not the best way to track it, but at least it is a tracking mechanism.

I'll have other comments later, but I think just keep that in mind of what you're talking about: a physician ready to go out, finished, ready to do that practice element, even if it's one or two years and saying, I'm going out. That's almost impossible today.

DR. KEMPER: Just a quick question, is there a time trend available on these unemployment figures?

DR. WILENSKY: No. There may also be -- can you make the information report available, would you mind, to all of the commissioners?

DR. LEWERS: I think Sharon has it.

DR. WILENSKY: Great. Bill MacBain?

MR. MacBAIN: Just on that one point. It will be interesting if we can see how many of them remain without positions say six months or a year later.

DR. LEWERS: That data is in there.

MR. MacBAIN: On physician oversupply, I think the conventional wisdom is based on a time when physicians had more autonomy in determining what their fees were and what procedures they did. The notion was that if you had more than -- unlike oversupplies of other sorts of supplier in a marketplace, if you had more physicians they would simply charge more for their procedures and do more procedures to try and maintain an income.

Whether that was true or not, I think that's less true today simply with Medicare there's no control over what your fees are any more, except to the extent that you can do something with coding, and with commercial insurance, both with contractual fee schedules and precertification, there are other limitations. So I think that may ameliorate some of the effect of oversupply on overall cost.

I'm curious about the COGME figures, and I haven't read that stuff in a while. But I was struck on the graph that you presented that the projected required supply of physicians for population remains constant over a period of time when the composition of the population itself is changing, particularly in the years following 2010 or 2011 when the first of the baby-boomers begin to become Medicare eligible by future of their age. I wonder what would happen particularly if we extended that graph out past 2020 to about 2030 when we've got a large chunk of baby-boomers in that Medicare bracket.

At the same time, looking at the effects of an increase in the oldest of the elderly, does that really imply that the demand for positions per thousand population is -- that the actual demand supported by clinical need is going to remain constant? Because I would have expected to see that drift upward as the population changed.

The third point is the notion that oversupply might somehow result in worse maldistribution. I'm not quite sure how that's supportable. It did strike me that if IMGs have the highest frequency of not

finding their preferred positions, IMGs are also the ones that are disproportionately represented in health personnel shortage areas. I suspect there may be a causal effect that we might want to look at.

So the conclusion that I'm not sure that all of the things that we used to point to as being bad about an oversupply of physicians in today's context may be quite as much a concern.

DR. CURRERI: I wanted to make a comment on your first briefing paper here, specifically on pages 9 and 10. I guess this is probably perhaps just fuzzy writing and not fuzzy thinking, but you talk about the cost and the implications of physician oversupply. And I guess we have to define what a physician is, but a physician to my mind is someone who's licensed to practice medicine and surgery in any state. As you correctly point out in your last chapter, in all but four states you can practice after one year of GME. So you just need four years of medical school and one post-graduate year.

In fact, this is not an unusual occurrence, for a lot of reasons. Sometimes residents get into a transitional position in the residency and when your two years are up they can't find another position. Others get into a residency program in a more permanent way with a permanent slot but find that they're not interested in that specialty after two years, or the demands are too great, or the time considerations are too great, or in fact they can't keep up academically and are asked to leave.

Now many of these people go out and practice in general practice. They go to emergency rooms. They practice in emergency rooms. So I think you cannot equate physicians, as you have in the bottom of page 9, with GME. Physicians, to control -- and I bring this up because to control supply of physicians you really have to control the entrance into the first year of medical school. Because virtually everybody that finishes medical school will be able to practice if they want. Probably less than 1 percent go into a research career.

Now when you're talking about maldistribution of specialties, then you need to talk about GME programs. I think it's very important to keep these two things separate and not to equate GME with oversupply of physicians --

DR. NEWHOUSE: What about the IMGs?

DR. CURRERI: -- because the two have nothing to do with each other, and not to talk about maldistribution of the specialty mix as a medical school problem or of a physician problem, but that's a graduate medical education problem.

DR. ROWE: Are you saying that to control the number of physicians, we should control the number of first-year med students? Because that overlooks the IMGs.

DR. CURRERI: No, if you go back to GEMINAC, what GEMINAC did when it came out with its report predictive of a tremendous undersupply of physicians, the federal government went out and gave capitation grants to the deans to double the size of their class and encourage new medical schools, 30 or 40 of them, to grow up. It was a federal incentive to increase the number of first-year places in medical schools which led to this "oversupply" if that's what we have.

DR. ROWE: Some people think the IMG problem led to the oversupply.

DR. CURRERI: Perhaps. But I can remember in the 1970s in my school and every other school in the state, we all doubled our class size overnight because it was very profitable to do so.

DR. WILENSKY: Which just shows you incentives work.

DR. CURRERI: I just wanted to make one other comment on the access on page 10. I think it's incorrect to say that Montana, Idaho, and Alaska don't train physicians. There is a program there called the WAMI program in which Alaska, Montana, and Idaho contribute very heavily to the University of Washington

to train their physicians and send them back. So they have a taxpayer commitment and it's not quite accurate to say that they don't produce any.

DR. LEWERS: A couple suggestions on where I think you might go and to try to answer a couple of your questions. One of the areas where we are seeing these individuals that, as has been pointed out, are having difficulty getting positions and where to go, does that have an impact on individuals going on into specialties? If there's any data that you can find about that. For instance, if a resident comes out of a program and can't find another position, or can't find a job, does that individual then go back and get further training, so that they continue on and we exacerbate our problems with specialties?

The effect of oversupply on cost, et cetera, the factors you pointed out, and when I think of oversupply, I should have said earlier, I think we have a total oversupply. I think that it varies certainly by specialty, but some of the data that's coming out now indicates that we have primary care oversupply at this point in time and yet we're still building new D.O. schools, which the majority of them still go into that. So I think we have to somehow comment on that.

The other element of oversupply also applies I'm assuming. Craig, you've said that we were going to talk about the nurses and P.A.s and all next month. But I think we just can't simply talk about an oversupply of one segment of the health care community. We've got to include all of that and I assume that's what you're going to do.

The other question is looking at whether we can learn anything from international data. We know that there are oversupplies, particularly in Europe and in some of the other areas, and can we learn anything from that? What happened? What went on? The systems are different -- I realize that -- but whether there's any data on that.

You ask about what effect do Medicare policies have on physician supply? I think you need to expand that because it may not be Medicare even though that's what we're directing. But in this area I think we have to include a number of areas. What about our immigration policies? What about our underserved area? I'm told -- and I haven't been out and counted them -- but that Cook County has 5,700 empty beds but still has 33 shortage areas and medically underserved areas. And there's a bonus that comes into some of the training programs to get physicians to fill those areas. So I think those policies have to be added on.

I think this all relates to the total picture, but I think these are more related to the supply problems, although we'll be talking about that. What about the J-1 visa, for instance? Yes, they have to go back, but there are so many waivers and anybody who has any political pull can get a J-1 waiver and the individual stays here. So should they go back? Should they be forced to go back? Should we still have waivers? I think all of those are areas that need to be addressed when you start talking about supply.

DR. NEWHOUSE: I'd like to come back to your broad questions and echo some points that other people have made. I'm not sure I'm totally comfortable with the way you framed the first question, what biases, if any, exist in the payment system that might lead to an inappropriate supply, et cetera. It seems to me that implies we know what's appropriate.

MR. LISK: No, it doesn't. I mean I'm not trying to say it does, and actually part of it's just in terms of just thinking about -- what I was trying to convey there in terms of just the questions for your thinking was, thinking about what the education system, what the financing system, what the payment system might have in influencing supply, specialty distribution and that stuff. And that's all that's intended to --

DR. NEWHOUSE: That's a different question than you've written down.

MR. LISK: But I'm just trying to get your discussion in terms of thinking about them.

DR. NEWHOUSE: But you could drop inappropriate then out of that question. You could say what factors exist in the system that affect supply, patient mix, et cetera.

MR. LISK: Sure.

DR. NEWHOUSE: That's a very different cast of question, I would suggest to you.

DR. WILENSKY: Just accept framing that without the word appropriate.

MR. LISK: No, that's perfectly fine. We're just trying to get your discussion and thinking about that.

DR. ROWE: And having no trouble at all.

DR. NEWHOUSE: But then the question is, having identified the effects, what are we to make of them? I mean, I can convince myself to my satisfaction that the subsidy to residents in Medicare has increased the number of IMGs and residents, as your numbers show. That then leaves us with a question of, do we think that's a good thing or a bad thing? So dropping out the inappropriate is not --

MR. LISK: I have no problems with that.

DR. NEWHOUSE: Then I'm not sure what -- we're still left with the issue of, do we think this increase in IMGs is a good thing, a bad thing, or do we not care about it?

DR. MYERS: We care.

DR. NEWHOUSE: We care. Some of us care.

I think the larger issue is, are we going to try to leave workforce issues primarily to the not-so-tender mercies of the market or are we going to have a more de rigiste approach? For myself, I'm on the market side. I'm a little like Winston Churchill, the remark about democracy, that the market was maybe the worst thing, but better than anything else. I would suggest you might want to look at -- there's an exchange the

John Eisenberg and Uwe Reinhardt had at PPRC that they then decided to write up an inquiry where they took two sides of that issue and you might cite it.

In terms of, however, the overall supply, I would emphasize what Judy said, that we seem to have a singularly poor batting average for making pronouncements here insofar as we can detect it. I think one of the reasons for that is a point that Woody alluded to, which is all of the projections that we've made in the past -- this is the National Health Manpower Commission that Bill Curreri referred to that said in 1968 we had a shortage, and GEMINAC in '79 that said we had a surplus.

They basically all took the technology of the day as a given. And if you look at what has happened over time, I think you can't fail to be impressed with the number of new procedures and other activities that physicians can do. In 1968, we basically didn't have, for example, angioplasty, and dialysis was kind of a gleam in Seattle -- a little bit more than that. I'm with Woody. I think it's very hard to know what's going to happen in the future.

But I think that doesn't -- there's some other reasons that are involved with Medicare's role in GME, certainly on the indirect cost. But that's a somewhat different set of issues than the overall supply of physicians.

DR. WILENSKY: You also have the probably singular misfortune of having two people sitting up in front who have done some research in these areas that you're talking about. And since I'm one of them let me -- I think the point that I was trying to make and there's one article cited. Lou Rossiter and I did a series of five articles on this issue of how numbers affect cost.

Basically what we were finding, even 15 or more years ago, Bill MacBain, is in support of what you're saying now, although I'm sure what you have said is a much stronger phenomenon now, which is it wasn't numbers per se that would drive expenditures; it was the insurance that people had that would drive

expenditures in terms of having the relationship between supply of physician and spending. I suspect that's even much more true now than it was in the late 1970s.

What it suggests, and it really goes to Ted's point about what we can learn from international. I think that including information will provide perhaps some interesting background. But because the impact on spending is so dependent on the insurance arrangements that in fact the answer is probably won't learn very much because our reimbursement systems are so different from Germany or Canada or the U.K. that the implications of surpluses and shortages relative to other points in time has very different effects.

But I do think that the concerns about numbers per se driving up spending is really not, at least what we were finding. What we were finding was that it was very sensitive to both the health care needs of the individual and even more so to the insurance that individuals have. Given that that's changed so much, I think that any concerns of driving spending just because you have increases in numbers of physicians is even less likely than it was in the last 1970s and it wasn't very likely then.

But it raises the additional issue that we're in flux now in terms of organizational structure. I guess to go back and raise the point that both Judy and Woody have raised, which is looking at projections that base requirements on numbers per population -- I mean, it was hard not to smile when you said, assuming managed care becomes the dominant organizational structure in the future.

Well, I think that the most interesting thing right now is we have not settled on what our future organizational structure. I don't think it's going to be a la carte fee-for-service medicine. But whatever it is, it's not exactly where we've ended up right now. And that whole organizational structure, if it's some mix of much more consumer involvement, some at-risk plans that marries physician practice management with at-risk companies that pair with hospitals. I mean, I don't know what it's going to be.

But the only thing I think we can say is that it appears that we haven't found it yet. I think it makes it, again, highly risky to look at projections based on an organizational structure that might have been in place

in 1988. In fact, I think you'll find our batting average has been really poor in terms of figuring out what we'll need at a future point in time.

MR. MacBAIN: A couple of points. One, to get back to Joe's comment on the market being the worst possible way of allocating resources except any other way which I think -- I mean, that's how we do it. If you looked at how we deal with pockets of scarcity of physicians, health professional shortage areas, we rely on attractive forces such as loan forgiveness and cost-based reimbursement to organizations that physicians practice in and so on.

But also we rely on sort of a push out from areas of oversupply. Anything that pinches off the pipeline that's creating that oversupply is going to reduce that economic push. While it may result in some improvement in some other collateral consequences of oversupply in metropolitan areas, it's also going to be expressed in making it more difficult to deal with professional shortages in both urban and rural areas.

So I think we need to look at that in this whole concept of physician oversupply. Even if there is an oversupply in aggregate, that oversupply still isn't great enough to push enough people out into health professional shortage areas to solve that problem. So by solving whatever problem there is to the oversupply in aggregate, we're making the maldistribution problem more intractable.

DR. WILENSKY: Joe asked to comment on that point, then Alice, then Judy.

DR. NEWHOUSE: I have an aversion to the trickle down word. I'd like to use spread out. I agree with the general concept of the push, but the concept of trickle down implies that we kind of fill up the

metropolitan beaker and then a little few drops spill over into the non-metropolitan beaker. In fact, if you look at the data it's much more a spreading out, which fits the concept of the general push.

MS. ROSENBLATT: I have a couple of comments that may be naive comments because I don't know too much about this particular subject. Just some suggestions on areas for research. One is that most managed care plans have ratios of primary care physicians per 100,000 members, specialists per 100,000 members and I don't know if that -- I mean, particularly since there's already some work going on to survey managed care plans about methods of reimbursement.

If at the same time some data could be collected on those ratios which could then be used for comparison, particularly if we could categorize the managed care plans into narrow access versus wide access, that might provide some sort of range and just a benchmark.

The other thing is in terms of the geographic supply. Managed care plans and employee benefit consultants and brokers use a software program called GeoAccess and that actually maps primary care physicians within X number of miles, and you can set the parameter, and certain category of specialists within X number of miles. Again, it might be interesting to talk to some employee benefit consultants and brokers and find out when they use this software what ratios are they looking for, and what in fact is out there.

The other thing to me is, when we're using measures of per 100,000 population the needs of the under-65 population for care are very different than the needs of the over-65 population. So if we could change the measurement and look at per 100,000 of over-65 and per 100,000 -- you know, separate it that way. Because again, I think that a Medicare risk plan is probably looking to recruit physicians into a network using per member, which in that case means per member that is over 65. So that might again give you some segmentation of the population.

DR. LAVE: I had sort of three comments which really are based on some of the other ones, one of which is a confusion I had in reading that paper. That is, why an oversupply of physicians who are looking for jobs could lead to a deterioration in the quality of care? I would have thought that it would have been the other way around, because they would have more time or -- I mean, I found it confusing, your arguments. I liked the second one better. And I couldn't quite follow it.

It seemed to me that if I'm going to be working shorter then I'm going to be exacerbating the problem even more. I just found that a little confusing.

The second issue has to do with --

DR. WILENSKY: Do you want to have somebody respond to that?

DR. LAVE: Yes, you can respond to it, why it would lead to a deterioration in the quality as opposed to an improvement in the quality?

MS. WALTER: I think that there were two arguments that I made in the paper and that have been cited over and over again. There's the one argument that increased competition for patients are going to result in people spending less time with their patients because they're fighting for more and they want to --

DR. LAVE: But you see, I would think if I was fighting for more patients that everybody is going to have fewer patients and you would fight on a quality issue.

MS. WALTER: I think that the cost -- these are just the arguments that are posed, that the costs will go down because of the competition, so you need actually to see more patients in your practice, so you're spending less time with them. But I did present the other argument and that we've heard a lot of, which is what you're arguing, is that because there are so many physicians that it may be that they do have that opportunity to spend time with the patient because there are indeed fewer of them.

DR. WILENSKY: And also an attempt to try to differentiate themselves in some way.

MS. WALTER: Absolutely. To talk with them and --

DR. LAVE: You may just want to reverse them because usually the one that comes first you think is more important than the one that comes second. Theoretically, if they are going to see more patients, less per patient, the problem then gets worse, right, when we have more physicians than we need?

MS. WALTER: Yes.

DR. LAVE: The second issue has to do with the forecasting of the future, which is really where we are and I think you've heard a sense among us that it's very difficult to do, which doesn't mean to say that you can't look forward. And one of the words that we haven't heard in here, and it might be in here, is not only the genome project but also telemedicine, which clearly is going to change the whole aspect of care in rural areas.

Thirdly, and Joe, I wish you'd pick up on this as well, which has to do with sort of the shortage area. My understanding is that the shortage areas continue to be shortage areas in spite of the fact that the number of physicians per capita in those areas continues to rise. So in some of those areas where we have shortages we also have problems of increasing physicians. I think the other concern that one has is that whether or not it's a shortage area, but whether or not there was a market problem, because if nobody can pay for care, why would people want to go?

So I just sort of again come back to some of the confusions that we have in terms of trying to use economic concepts like -- shortages and surpluses are often very different in the health care area than any place else. Because you know, traditionally in Economics 101 if I have a shortage I expect the price to rise. And we observe these areas where in fact we have shortages and the prices are slow because there isn't any demand for care because people are impoverished.

Another issue which is the same issue, and this came to mind is that we talk about professions in shortage and yet they are the ones that tend to have the lowest incomes, again which tends to be not exactly consistent with an economic model. This came to mind because of something that you pointed out. One of the things -- and I think we have to try to be consistent in the way that we think about this in the report, and it might be helpful.

Because for instance, in part of the report you keep talking, but we have this problem with maybe we don't have enough primary care physicians. And we're going to come back to this issue because I think we really do have to talk about the nurse practitioner issue before you address the primary care physician.

But you then looked at this problem that said, I did this study and I found that the demand for internists in the articles was down. Now somehow or other, it's going to be difficult in one chapter to say, there's an oversupply. I have this problem. The indication is that the demand for internists is down. I know what you're going to -- and then in the next chapter we're going to be saying, and we have a problem with the primary care mix and general internists.

So I think we have to be very consistent about -- and we may want to even have a section that talks about sort of the confusion, or problems with sort of using these terms and looking at sometimes what the market -- that our rhetoric and the market signals often go in opposite directions. I think it might be useful to point that out.

MR. LISK: What I wanted to actually say is I think you may want to present some of the other information because a lot of the issues people are touching on are going to be discussed in some of the other presentations for this morning.

The other thing too in terms of the papers, the papers are works in progress and are not necessarily specific chapters at this point. So they're more of discussion documents for you to help us decide how we're going to shape the final papers when we talk about this.

One of the viewpoints, at least in the initial discussions providing the data in terms of the facts of the data that we have on the different pieces here in one section, and also though talking about some of the issues that a lot of you are bringing up here in terms of the some of the quandaries that you have in terms of talking about physician oversupply or not, and some of those, and eliciting some of those discussions there.

So there's going to be some reorganization of what comes on in terms of what's going to be a final product that we produce. So I want to --

DR. LAVE: I'd just like to say something.

MR. LISK: So any ideas you also have along that line is helpful.

DR. LAVE: I hope that you consider all these comments as very helpful criticism because we really -- if we spent all the time praising your work we wouldn't get on to being able to help you out. Periodically we sort of jump in all these criticisms without indicating in fact that if we hadn't had such an excellent piece of work in front of us we wouldn't have been able to comment on it and try to make it better.

MS. WALTER: I think in some regards I think they are a little bit schizophrenic, but the intent was really to try and say, on the one hand, the data is saying this, but on the other, this is what's happening, as you had pointed out. So I think you do sort of get that sense of schizophrenia. But it was intended to be more even-handed to try and give you a fuller picture.

DR. WILENSKY: Gerry, do you want to comment at this point?

MR. SHEA: I'd be happy to hold my question. I just will say that I'm sorry to see that the commissioners don't have any strong opinions on this question.

[Laughter.]

DR. WILENSKY: Dr. Rowe, would you like to speak now or wait until the next session?

DR. ROWE: My need to criticize is under excellent control. I'll hold for the moment.

DR. WILENSKY: Craig, the next session.

MR. LISK: Susanne and Deborah will both talk about the specialty distribution.

MS. WEINRAUCH: First we will review the actual and projected supply of generalists and specialist physicians. We'll discuss evidence of how the market is working to control the supply and demand of primary care physicians and specialists. We'll go over some factors which may affect the supply and demand for physicians, and some implications for federal workforce policies. And we'll summaries with the basic issues.

Primary care is person-oriented and addresses the majority of health needs including physical, psychological, and social concerns, whereas, specialty care is more disease oriented and organ specific. Primary care focuses on health promotion and disease prevention, and specialty care focuses on the concentration on area of specialty.

By primary care we mean family practice, internal medicine, pediatrics, and Ob/Gyn. The length of residency training is three to four years. Specialty care includes all other fields. One can apply for residency specialties during their senior year of medical school or they can apply during residency for a fellowship position if they choose to subspecialize. Residency specialty training are for three to five years, and fellowship training is one to four years after completing a residency in primary care or general surgery, which is five years.

This graph comes from COGME in 1996. Basically the upper two lines are specialists and the bottom two lines are the generalists. They projected the requirement in

the 21st century to be 60 to 80 per 100,000 and their requirement for specialists to be between 85 and 105 per 100,000. According to their projections, in the 21st century we are meeting the requirement for generalists but we have an excess supply of specialists.

There are really only two aspects of Medicare policies that differentiate between primary care and specialty care. Hospitals receive 6 percent higher payments for primary care residents than for residents in other fields. Payments are reduced to one-half FTEs for residents training in a second specialty after completing their first board eligibility program, after five years, or after whichever is shorter.

The jump in resident specialists is relatively recent. The increase in the number of residents training in specialty fields as compared with primary care began in the early '80s. In '81 there were more primary care residents than specialty residents. With the exception of Ob/Gyn, there has been a general upward trend in residents training in the primary care specialties. Pediatrics has remained basically unchanged between '96 and '97, and Ob/Gyn has been decreasing since '93.

When you look at selected subspecialties you see a mixed picture. Emergency medicine, and geriatrics to a lesser extent, have both increased. Anesthesia has been the hardest hit in terms of declining number of residents. We also see a slight decrease in cardiology training. General surgery has been more or less constant since '80 and has decreased to a lesser degree over the last few years.

DR. WILENSKY: Do you have any ideas, Susanne, if you were to plot nurse anesthetists along that anesthesiology line, what it would look like?

MS. WEINRAUCH: I don't.

DR. WILENSKY: Just to get back to some of the conversation that these are difficult discussions to have in isolation.

DR. CURRERI: I think also this is one area where you do have to take the nurse population in because the nurse anesthetists have taken over a lot of the area.

DR. WILENSKY: Yes. Sorry, go ahead.

MS. WALTER: If you disliked the first part of the presentation, you're going to hate what's coming up here.

[Laughter.]

MS. WALTER: There are some recent trends suggesting that market forces may be working to correct the specialty imbalance. As Susanne pointed out, there appears to be a general increase in the number of residents in primary care and an overall decrease in the number of residents training in subspecialty disciplines. The most pointed example is the sharp decline in the number or residents training in some of the hospital-based specialties such as anesthesiology.

As another example, some recent data show that 37 percent of resident physicians completing training in hospital-based specialties in 1996 experienced difficulty finding a practice position. However, there was also significant percentage of graduates in primary care residency programs who were having just as much, if not more, difficulty securing a position in their field than are graduates in some specialty residency programs. As you can see from this slide that 23 percent of internal medicine residents and 17 percent of pediatric residents reported significant difficulty finding a position.

DR. NEWHOUSE: Should I understand that they completed on June 30 and the survey is done between May and August?

MS. WALTER: Yes, so some of these -- they did three sort of rounds of a survey. They needed to try and at least establish some baseline or contact with the actual residents before they left training. So that happened in May. Then they did subsequent follow-up mailings between that time, May, and actually it

went up to November. All the responses that you see here are up to November is what was included in the data. So in total it's a six-month period.

Even more interesting is, among the 31 specialties reviewed by Miller and her colleagues, internal medicine ranked sixth behind the subspecialties of hematology, pathology, and the others that you see up here in terms of the percentage of graduates who did not have a position upon graduation. These results suggest that market forces may be limiting opportunities for newly trained internists. It also suggests that the system may be less able than it once was to absorb the additional number of physicians.

Another recent market trend is the resurgence in the number of allopathic medical school graduates interested in primary care specialties. The percentage of graduates planning careers in the primary care specialties has increased steadily from a low of 17 percent in 1992 to 44 percent in 1997. Among the four specialties, family practice has experienced the greatest gain, from 9 to 24 percent as of 1997.

While there are many factors that influence specialty, and obviously we've talked a lot about those, I'm only going to address two of them. One is the dramatic rise in the projected numbers of non-physician clinicians. I will refer to them as NPCs. That rise has been from 228,000 in 1996 to a projected 384,000 by the year 2005. They will likely have a significant impact on the future need for physician services. These groups are typically performing services that were once considered to be exclusively within the domain of physicians.

There was also some evidence that HMOs are increasingly substituting some types of NPCs for residents and even for primary care physicians. The sheer volume of NPCs expected to graduate over the next decade is expected to have the greatest impact on future demand for primary care physicians.

Our country is also aging rapidly. It is projected that by 2030, one out of every five Americans will be over the age of 65. In addition to longer lifespans, the nature of illnesses are changing.

People are now living longer within disabling chronic conditions, primarily as a result of medical advances, surgical interventions, and pharmaceuticals. With our aging population, it is expect that the elderly will require more care services from specialists.

What are the implications for federal workforce policy? As you can see here on this slide, Veterans Affairs, the Department of Defense, state Medicaid programs, and the Public Health Service contribute approximately $2.5 billion in support of residency training, or approximately 25 percent of all federal support. By striking contrast, Medicare alone contributes $7 billion, or 75 percent of federal support, for its share of graduate medical education costs.

Ironically, while Medicare's contributions dwarf the contributions made by these other federal programs, it does so without any clear objectives. This markedly differs to workforce programs such as the Public Health Service that has specific uses for its outlays for graduate medical education.

Although Medicare was never intended to be used to set workforce policies, it has a tremendous impact on how programs are structured by virtue of the money it pours into the GME system. If Medicare continues to fund a surplus of physicians, it may be useful to assure that the financial support is targeted in a manner that compliments the specific objectives of some of these other federal programs, or at least is targeted in some more purposeful way to effectively serve the health care needs of our nation.

As an example, the American Geriatric Society has recommended that all health care professionals, physicians, nurses and others, need adequate training in geriatrics, including end of life care and palliative care.

In another vein, with new techniques and advances in technologies, providers are increasing able to perform specialized procedures in an ambulatory setting rather than in an inpatient setting. Today, the critically ill or dying represent a smaller proportion of the practice. Conditions and diseases that were once

common in the hospital setting are increasingly being treated on an outpatient basis. Typically, most patients enter the hospital with a diagnosis, treatment plan, and predetermined length of stay.

However, hospital focused payments may not provide incentives to providing training and education that is most appropriate. Historically, hospitals have received Medicare payments so hospitals have been the sponsors of graduate medical education. This may influence the content of training. By comparison, specialty groups that could potentially sponsor graduate medical education training in more appropriate settings cannot currently receive payments for doing so.

DR. WILENSKY: Your chair and vice chair, by the way, would like to recommend that economics also be part of the requirements here.

DR. ROWE: I thought you were interested in content?

DR. NEWHOUSE: We have a textbook recommendation.

DR. ROWE: See, incentives work.

[Laughter.]

MS. WALTER: Just in summary, with respect to specialty mix there are four basic questions that we seek the Commission's input on.

Number one, are the incentives in the financing and training system that bias specialty choice decisions? Is the market effective in determining the appropriate specialty mix of health care professionals? Should Medicare and other federal programs exert more explicit influence on specialty mix? And finally, does the current GME financing system influence how and where residents are trained?

DR. ROWE: I have a couple things I'd like to comment on here. I appreciate this very much. I think that my point of view would be that it would be helpful to focus this area of discussion, since it's part of our report on GME, more on the Medicare population rather than some of the general workforce issues.

I don't know if we have more doctors than we need or not, but I think we have the wrong ones when it comes to taking care of older people, which is what Medicare is, I think, about in part.

I think that with all due respect to my colleagues in the American Geriatric Society, I think it would be good to focus more on what the Institute has had to say about this. There have been three very detailed reports by the Institute of Medicine in the workforce issues in geriatric medicine over the last 10 or 15 years. One, the Beeson report was the first one, then there was another one in the middle, then there was John Benson chaired the last one.

I think that these reports really focused on how many geriatricians are needed for X number of older people. As somebody said, rather than 100,000 of the general population, how many are there in the pipeline? How many do we need? What do they do? Do we need them at all, et cetera? I think those workforce projections might be appropriate.

This material, it does not include any mention of geriatrics. It's amazing. I mean, there's no section on geriatrics, and this is Medicare. Now geriatrics is mentioned. I want to be fair to you, it is mentioned. It's mentioned as a subspecialty along with otolaryngology and a couple other things. I know I'm a geriatrician and you can discount all this, but it's not a subspecialty. It's a superspecialty.

We take internists and family practitioners and we train them in psychiatry, urology, orthopedics and other things about old people that they didn't learn when they did their residency in internal medicine or family medicine. Geriatricians are the only people in the United States trained specifically to take care of the needs of Medicare beneficiaries. All their training is focused on taking care of the needs of Medicare beneficiaries.

So it seems to me that if that's true, there might be room in the report for some comment about workforce with respect to that, and I think the IOM is an area to look at.

I guess the other thing I would say is this second piece, which is what you said about the American Geriatric Society, has to do with the curriculum of -- and this is where Gail and I disagree -- but I may be able to trade economics with her for geriatrics.

The curriculum piece -- and let me tell you what I think people mean by that. That is, my mother is 89 and if she has a hip fracture, which I hope she doesn't, I want the anesthesiologist to understand how to anesthetize old people. I want the orthopedic surgeon to understand something about old people. I want the guy in the ICU to understand something about old people so they shouldn't get too much medicine or the wrong, et cetera, because all people aren't the same.

So I think that's the content piece that I would like to see somehow our incenting so that the Medicare beneficiaries who go to doctors get access to that kind of informed care. So there are the two pieces of it. One is, do we need geriatricians? What do they do? How many do we need, if any, et cetera? Which I think the IOM has an objective view of as opposed to the AGS, so we should look at that.

And the second is, how do we get this other piece of informed capacity into the general mix of health professionals?

Thank you.

DR. WILENSKY: Let me just make a comment in all seriousness about this issue about curriculum and textbooks. I think it is perfectly appropriate for the Commission to indicate concern about the lack of sufficient training in areas like geriatrics or in treatment of palliative care or care of the dying, and concern about whether enough time is being spent in the training of physicians in general in these areas or physicians that are specifically being trained to take care of these areas.

We can do what the commissioners wish in this area, but to go beyond that and to try to specifically survey which textbooks and curricula are used, and whether or not we think that there needs to be

specific changes as opposed to flagging that this is an area that people who have expertise in this, either as part of the accreditation process or a part of the training process, need to give more time, and we can do what we wish. Except for, Jack, it has been my sense that, and perhaps Susanne, that both among the staff and among the commissioners we do not ourselves have much in the way of expertise in terms of what curricula and textbooks ought to be. So it's really that.

DR. ROWE: I accept that, Gail, and I appreciate the chance for you and I to discuss this for a minute. I'm not recommending that we be specific with respect to the curriculum materials or something like that. I think there are other bodies who can do that. So I don't want to be misunderstood to think that so-and-so's textbook or so-and-so's --

What I am saying though, which I think is fair, is that we're trying to help HCFA be a prudent purchaser, and one of the things we purchase is health care for older people. One of the other things we purchase is GME. And if we're going to be a prudent purchaser and we're going to purchase GME that's going to improve the access or the quality or whatever of health care for Medicare beneficiaries, then it wouldn't be a bad thing for us to say, we think there should be an emphasis on this or that. We'll leave it up to some other body to say how to teach palliative care, or how to emphasize geriatrics.

But it's our responsibility, I think, as the Medicare Payment Advisory Commission to be prudent purchasers of all the products we purchase. I think it's our responsibility to make sure those products help Medicare beneficiaries. So that's all I'm saying.

MR. SHEA: I'm a true amateur so I probably shouldn't venture into these waters of curriculum and so forth. But I want to just --

DR. WILENSKY: Wade in.

MR. SHEA: I won't go as far as Jack about commenting on the wrong physicians. He actually told me he has a list, by the way, of the wrong physicians. He may or may not reveal it later.

[Laughter.]

MR. SHEA: But it does seem to me that for $7 billion that someplace in this analysis, in this discussion and certainly in the report we ought to be commenting on whether Medicare is getting the right set of professionals for the beneficiaries, and is there something that should be done about that if it's not right. I don't know how far we want to go into this, and I know our mandate here is to make comments on the financing question in regard to broad -- part of which is a broad physician supply.

But I do think that, at least from my interest, I think that it would be very important for us to make some comment that might be useful in this area. I'm not sure again how far we should or even want to go in that, and I don't think it's to textbooks certainly. But are we getting the kind of services and the kind of preparation for the services that this population needs to me, I think, is something that we absolutely should be commenting to.

DR. WILENSKY: In continuing our pleas for more accurate terminology, I think it is not appropriate to look at $7 billion of monies for training and are we getting our money's worth on that training. The fact is we spend about $2.5 billion on direct medical education. It is absolutely appropriate to say, are we getting our money's worth for the $2.5 billion in terms of training the kind of physicians that we need for Medicare?

The other pot of money, which we can either question its basic function and continuation is for indirect. It is presumably reflecting increased costs that hospitals have in terms of providing care to Medicare beneficiaries as training institutions. We can make any sort of statement about whether or not that is appropriate for the future.

But it just seems to me -- I mean, we might decide we'd rather have $7 billion going to purchasing the kinds of physicians or training the kinds of physicians we want. But when we use the prudent purchaser concept, it strikes me that that really is appropriate as an issue with regard to direct medical education expenses and that the indirect just has to go along a different line, which we can either say is reasonable or unreasonable to continue in the future, has no place in the future, whatever we want to say. But I really don't think to put the $7 billion in a single pot is right. I think it just mixes apples and oranges.

MR. SHEA: I realized when I said that $7 billion was both direct and indirect, and I don't disagree with there's a very distinct separation that should be made here. But even at $2.5 billion I'd say this is a significant question.

DR. WILENSKY: I'd accept that, absolutely.

MR. SHEA: I'm only making the point that I think that we could easily, and maybe even very usefully, comment on the financing question: is this money have a positive effect, a negative effect, a neutral effect, the right effect, the wrong effect on physician supply generally?

The point I'm making is that I think we have a responsibility in our role on behalf of beneficiaries to say, beyond that question, is it having the right effect in terms of the present and future needs of this population?

DR. WILENSKY: I would even put that as the first question.

DR. CURRERI: I am continually troubled in this discussion by the kind of artificial division that we make between "specialists" and primary care doctors. The reason I say that is because, particularly in the rural areas there's an enormous amount of primary care delivered by what you're calling specialists that we assume are giving no primary care. Even in the smaller metropolitan areas, there's a lot of primary care

delivered by cardiologists, gastroenterologists, et cetera, and in the rural areas much of the primary care is even given by general surgeons where there is a not very large contingent of physicians for the population.

I just wonder if there's any data available, because we're not really talking about whether they're primary care physicians versus specialist physicians. We're talking about primary care versus specialized care. And I wonder, for instance, a geriatrician I would consider myself a primary care physician for the most part but they're lumped in with the specialists here.

DR. ROWE: That's because they take another residency after the first one.

DR. CURRERI: Right, and that's the same thing with cardiologists and with pediatric hematologists and whatever. And I think a lot of primary care is delivered by these people. Are there any studies that suggest how we can factor that in?

DR. NEWHOUSE: There's an old study 20 years ago by Mendenhall that buttresses your point.

MR. LISK: Part of the issue there in terms of the policy debate that you'd have though on that issue though is in terms of Medicare in terms of what it's funding in terms of what is the efficient use of resources of Medicare funding, for instance, or the federal government's funding. Because we could train everybody in specialties to do also primary care, but that's part of the debate you need to have in terms of this discussion.

DR. NEWHOUSE: Craig, I think the point is the numbers you're showing us aren't helping us then come to a conclusion.

DR. CURRERI: That's right, that's what troubles me.

DR. WILENSKY: But I don't know you can do anything about it.

MR. LISK: I'm not familiar with --

DR. NEWHOUSE: No, I'm not sure you could do much about it.

DR. WILENSKY: Other than just comment and when you present it --

MR. LISK: Yes.

DR. LEWERS: Along the same lines that Bill is speaking of, the AMA introduced a program two years ago, we talked about I believe once before called primary care but also principal care, directed more at the HMO industry and trying to get away from this gatekeeper concept, and that the principal care is basically dealing with a specific problem and working with the primary care physician.

For instance, diabetics do better if they're treated by a diabetologist. That's principal care. So it's an area that we might want to think about too as we begin to get into areas that Bill is getting into.

I've got a specific question in the paper, but the other area you talked about, physicians finishing their training and not finding a place to go. Having tried to recruit physicians, one of the major areas in recruiting a physician is not whether the physician wants to come and would be challenged, it's whether the family wants to go. So there have been physicians that are available but the family doesn't want to move into that area. So these are complex problems. It's not pure and simple recruiting.

In your paper, this is the paper on the specialty mix, primary care, specialty, on page 7 there is a statement, an example you give, and I'm just curious if you have any information on why. It says that in '94, 67 percent of residents started in their training in primary care but by '96 only 38 percent completed the training in the discipline.

Do we know why that occurred? Is it because they went into specialty areas or flunked out or what?

MR. LISK: There's a couple things that happened there. One is that people start off in what's considered -- part of it is really to get a picture is when you see someone enter it doesn't say what the

final output is going to be, because people enter primary care positions which are one-year positions before they enter anesthesiology and some other types of specialties, for instance.

So when you finally get down to what the output is it ends up -- then people subspecialize into cardiology and those things, internal medicine, pediatrics, you get down to about 38 percent in '96.

DR. LAVE: This actually goes back to a conversation two people ago, and I'm sorry I didn't get in then. This has to do with the issue of -- I think it's an important issue for this report and that is, if we address the graduate medical education financing as a Medicare issue, or if we regard it as a federal issue, I think we may come to different answers if we put it in that particular way.

So we've heard some conversation here, as Medicare

as a payer, are we doing the right thing? That would imply that the idea is that we're going to continue to do this through the Medicare program.

But if we're supposed to think more broadly, I think we have to change the focus of the question about -- and we may want to be very clear about this. That one may think about this issue differently if one was thinking of this issue as a payer, or if one was thinking about this issue as a federal responsibility. And you may not want to do it as a payer and you may want to have a broad, general policy.

And I think it's a bind for us because we're the MedPAC commission. But on the other hand, this is supposed to be a general report on graduate medical education. So I think we have to keep that straight. And I have to confess that this point is raised to show that we can all be lobbied by going to a talk given by a pediatrician who was pointing out how there is no sort of federal payment source that gives money to pediatrics if you're in a children's hospital.

So that was one of the things that it did lead me to reflect that in our report anyway we have to be definite about are we talking about Medicare or do we want to talk about federal payment policy for physicians?

DR. WILENSKY: My understanding is that we are both entitled and probably should raise this from both perspectives. That is, our perspective as a payer is this. We think, to the extent people care about our opinion in this matter, that with regard to broader federal policy, here's a role. And I think it's obvious, since people have raised this point, appropriate to say that if we were making a change, we're very concerned about the sequence in which a change is made. So that we might think the better mix would be to have Medicare doing one thing and a different from current role for the federal government, but we would recommend that the change not occur until the federal government --

So that we certainly are entitled to be careful of saying, if we want to move some things that are now done by Medicare to a broader context of the federal government, that we would like the move to only occur when the federal government has picked up the other piece.

DR. ROWE: Can I just respond to this, because I gave the apologia for focusing on the beneficiaries of Medicare? I accept this fully. I think that if would be appropriate for us to look at it from two points of view. But even if you move it out of this program -- and I gather the legislation indicates that should be done when a better place is found for it, or whatever, as we discussed last month or whenever. If it's moved out in part or in whole of this program to something else, that wouldn't mean that Medicare beneficiaries, who are still people who use 25 percent of the health care in the United States, wouldn't ben an appropriate group to be focused on, amongst other groups.

DR. LAVE: I concur.

DR. ROWE: So I think that it doesn't erase the interest, it just doesn't focus it quite as much or solely. But I think it's a perfectly reasonable way to talk about --

DR. WILENSKY: It also could be that we recognize a reduced and diminished role for Medicare, per se, a different or bigger than current role for the federal government, and that again, we're just concerned about the sequencing. Now we don't have to make those conclusions, but we certainly could do that and be consistent with what our charge has been.

DR. NEWHOUSE: Let me agree first with Judy's last point. It's funny I was also lobbied by the children's representatives.

DR. WILENSKY: As was I.

DR. ROWE: As was I.

DR. NEWHOUSE: That clearly points in the direction of some kind of general revenue responsibility. I was going to come back to Jack's point about geriatrics and the bullet on the slide that said, should Medicare and other federal programs exert more explicit influence on the specialty mix.

First some observations about if we'd have been projecting what we wanted to see happen to nephrologists

in 1950, we'd have probably been off, or for cardiac surgeons in '60, or for cardiologists in '70, I suspect we'd have been radically low in all of those cases.

Now all of those are examples of where there was major amount of technological change. And while I'm certainly willing to believe that Jack is right about geriatrics, I haven't read the IOM studies and, as I say, our record in this domain hasn't been great. I suspect that geriatrics probably is not so vulnerable to technological change.

DR. ROWE: Unfortunately.

DR. NEWHOUSE: But that, in a way, should give one a little more comfort in projecting.

DR. CURRERI: I'm not so sure of that because they're now doing transplants on 70-year-old people, liver transplants.

DR. ROWE: I think if we come up with a treatment for Alzheimer's than the numbers would change. But we have about 9,000 certified geriatricians in the country. The IOM says we need 36,000.

DR. NEWHOUSE: The issue is where they got that number.

DR. ROWE: Even if they're wrong by 50 percent it's still --

DR. LEWERS: Objection.

[Laughter.]

DR. NEWHOUSE: The other thing that occurs to me in this discussion, and I can't get the obvious implication for geriatrics, but the Cooper studies on primary care actually makes something of the constancy of the primary care to population ratio, despite the definitional problems, over time. In fact it also seems to be the case more or less over space that the ratios across countries are not so dissimilar.

And the inference he draws is that primary care hasn't much changed over time, and demand for it hasn't changed that much over time either, although despite the increased insurance. So it may be that productivity increases have offset, or the ancillary personnel have offset the increase in demand. So it's been reasonably constant. Therefore, that makes him comfortable projecting that off into the future as needs, which COGME has picked up on.

However, that's starting from a situation where you're saying, things seem like they're in steady state and they don't seem like they're going to change much, so we'll just go on in steady state. That doesn't sound like Jack believes that or the IOM believes that's true in geriatrics. So then the issue becomes how we appraise these estimates.

So I'm willing to entertain the notion that we might want to say something about future demand for geriatricians but I think we have to frame it then that way, and we probably ought to read at least the executive summaries of the IOM reports if we're going to do that.

DR. WILENSKY: We can certainly have that material distributed.

MR. MacBAIN: I had a handful of things. One is to follow up on Bill Curreri's point some time ago about specialists providing primary care. This is anecdotal but I think indicative. It's from one large multispecialty group that I'm very familiar with, but also from others when I've talked to people over the years.

That was the reaction in these groups as they decided to add departments in family medicine several years ago, and the reaction by specialists, particularly medical specialists that this was going to have an impact on their earning potential. I'm not sure that it did but there were certainly that perception, that they were providing a significant amount of primary care.

On the subject of a group practice and talking about the difficulty of residents finding positions after graduation, is there a way of measuring the effect of residents' tendency to look for group practice positions? I think it's been increasing over the years. I haven't read anything on it recently, but is this a phenomenon of people looking for certain types of positions, for positions in multispecialty group practices where you'd expect to have a limited number of open slots and they're having difficulty because they're not finding what they're looking for even though there are other types of positions available?

The third thing that concerned me and in a couple of the slides it was clear that the statistics dealt only with allopathic positions. I'm not clear across the board whether all the numbers we're looking at include osteopaths or not. But it doesn't make sense to me to leave that out. I'm not quite sure what the reasoning is behind that, whether the numbers aren't available, but it could make the numbers overall a bit more comprehensive.

A fourth point is just a technical one and that was on the study that was based on residents having difficulty finding positions based on a survey done between May and August but including responses through November. Does that also adjust the responses for those people who found positions between May and November or is this cumulative? Because that again could produce a different answer.

DR. NEWHOUSE: What's the answer?

MR. LISK: I think they're just trying to get back at their response form, so I think there is some potential problem.

MR. MacBAIN: So if you said no in May and found a job in July, you're a no?

MR. LISK: That's my understanding.

MR. MacBAIN: If you held only onto your form and finally said no in November, you're a no.

MR. LISK: That's my understanding.

MR. MacBAIN: So it's not really clear what we're measuring with that.

Another issue -- you caught me with a grab bag of things. In looking at the effect of HMOs on the use of non-physician clinicians, the model that I have in mind is the prepaid group practice model where the group practice itself makes decisions about whether to hire non-physician clinicians.

The predominant model of HMOs now is so much broader than that with the network models. I'm not sure that the HMOs themselves have a whole lot of impact any more on deciding how much care is provided by non-physician clinicians as opposed to physicians. It seems to be much more in the control now of individual practices that are not owned or controlled by the HMO.

It's more of a general comment. As we look at the impact of managed care on practice patterns, to recognize that the predominant model of managed care has changed a lot from the classic Kaiser prepaid medical group practice model.

Then finally, and this gets back to Judy's point. I don't want to get too deep into this now, but there is that ambiguity in the statute and the legislative history of Medicare as to just what we're trying to accomplish with payment for graduate medical education.

With the indirect it's clearly payment for the cost of providing care to our beneficiaries. But even for the direct, that's how it got in there. It got in there as part of the allowable cost of providing care in a teaching hospital. But the legislative history also makes it clear that this is recognized as something different. The first shoe was dropped I guess in the original act as saying, we'll do this until we come up with a better way of funding.

Maybe our conclusion should be that we have now been invited to drop the other shoe and say, is there some other way of dealing with this? But I do think that we need to be clear on our approach whether we are looking at just the funding for direct graduate medical education and looking at that as what it's called, and that is direct financing of education and not purchase of services. Or are we looking at this broader issue of how do we deal with all the collateral costs of running teaching hospitals?

We may not want to do that. We may want to keep the focus a bit narrower.

DR. WILENSKY: I think the issue about what role we see for indirect medical education in the future is an appropriate discussion. I just wanted to be sure that when we were talking about the $7 billion that Medicare was using with regard to purchasing -- whether it was getting its money's worth, that we remember when you talk about getting your money's worth it seems to me a more appropriate terminology to

use with regard to direct. I didn't mean to suggest that we not talk about indirect, we just talk about them separately.

MR. MacBAIN: But I think we're not at that point talking about the cost of graduate medical education.

DR. WILENSKY: Right.

MR. MacBAIN: We're talking about the costs of securing services for our beneficiaries in complex institutions.

DR. WILENSKY: Exactly, right.

DR. LAVE: I just wanted to make sure and I think that this may help us. My understanding is that this report is supposed to be broader than the overall Medicare program, isn't it?

DR. WILENSKY: That is my understanding as well.

DR. LAVE: So that's why the issue of, sort of the financing issue and who we're paying for I think --

DR. WILENSKY: It is not, however, all issues with regard to graduate medical education and training and workforce. It is just that in the areas in which we were asked to comment, which are a limited number of areas, it was not only within the mindset of Medicare. So it is both broader and narrower in terms of --

DR. ROWE: That's why we should handle it both ways.

DR. WILENSKY: Exactly.

DR. ROWE: Deal with it on the one hand, on the other hand.

DR. WILENSKY: Well, just this is what we think the role for -- we think there's a particular role for Medicare.

DR. ROWE: From the point of view of Medicare, X. From the broader point of view, Y.

DR. WILENSKY: Right.

Let me raise an issue now for commissioners' consideration. I think this has been by far the best discussion of graduate medical education that we've had as a commission just in terms of raising issues. We're going to be meeting again in three weeks. One possibility at this point would be to take up the issues of the IMGs and geographic issues in December, because we have several other serious topics. First have a time for public comment.

Alternatively, we could do the IMG and then take up the geographic distribution. But I'm not sure that those two aren't, at least in some ways, linked. So it may be that if we're not going to do both other areas, we'd do as well to just take this up in December as the next round of GME issues, if people are comfortable doing that.

DR. ROWE: From my point of view, this is really still for this report that we're going to send in the end of the summer.

DR. WILENSKY: Yes.

DR. ROWE: We have two meetings and two reports before that that we have to get these other issues done for.

DR. WILENSKY: Right.

DR. ROWE: So why not let it slide to the next meeting, so we can help the staff by giving them the comments on things that they have less time to prepare.

DR. KEMPER: Could we take one more of the topics and compress a little bit in the afternoon?

DR. WILENSKY: We can, that's fine. I think of the two I would rather take the IMG next, if we're going to take one rather than the geographic distribution issue.

DR. MYERS: They're both [inaudible].

DR. WILENSKY: That was the reason why I was reluctant to do this. I think we may in fact -- I don't know whether we'll use all the time allotted for the afternoon. I do think we are probably going to use the time allotted for the outpatient hospital PPS. Is there a sense that people --

DR. MYERS: Are you looking for a motion?

DR. WILENSKY: I guess a nod. Are people comfortable if we postpone both?

DR. MYERS: Yes. I think they're going to both need a great deal of time.

DR. WILENSKY: I think the IMG is going to be contentious, so I'm a little --

DR. ROWE: It will guarantee a good turnout again at the next meeting.

DR. LAVE: We may want to increase the time that's given to them.

DR. WILENSKY: We'll look at it. I think the distribution more. I mean, we won't go later than we're scheduled today, next time. We may look and see how we allocate the time.

Are there any further issues? We can have some discussion, Craig, about what we'd like to see in addition to those issues. I think there may be some different discussion that you will find useful to present to us with regard to the issues based on the discussion you heard this morning. That is also one of the reasons why we thought postponing it might make the discussion more meaningful because you'd have the advantage of today's comments.

MR. LISK: Okay, that's fine. I think we can talk about other things, because there's a lot of things we have to cover over the coming months and stuff too for discussions dealing with some specific issues that we can follow up on at different meetings. So that will be fine.

DR. WILENSKY: There is the other possibility, and we can just have people think about this, is that we could have a February meeting. Next time -- I mean, we have to be sure that December and January are primarily focused on our March report. We can see how we're doing. We could have an abbreviated meeting, to the extent that we felt that there were more issues in GME than we were able to do.

I don't know that we need to make that decision now, but we can see how we're doing, and have an abbreviated meeting that would just be focused on GME issues if we feel like we have compressed too much. I'm not sure that we'll need to do that, but if people are -- they can just think about that as we go forward.

Let me open this up for public comments before we go to the outpatient.

DR. LEWERS: So that I don't forget this I want to answer or make a comment about somethingn Judy said. I was saving it for geographic distribution and I'll forget it. She talked about Economics 101 and how if the money is there or not there and people are going where it is.
Economics 101 also I think goes a bit further into something called price controls. So we can't talk about Economics 101 and the demand issue of people moving from one area to the other in the face of price controls.

So I'll let you debate that perhaps when we get into geographics because that's what we're living with. So Economics 101 just went to Economics 103.

DR. LAVE: Could I just comment, Ted? When we had Economics 101 before as much price control as we have now, I think if you looked at prices you would have found that the prices were actually lower in the areas that we characterize as shortage areas and higher in other areas.

DR. LEWERS: Maybe we won't forget it when we get to that.

[Laughter.]

DR. WILENSKY: Actually, the thing that is interesting is that both the primary care in the rural areas, both because of third-party payment history and how prices had gotten established, actually we used price controls to bump them over what they had been. Whether or not, if you have a more market sensitive environment than we had when third-party payment was the dominant price-setter in the '50s and '60s that this was coming from, whether we would see now in fact a bump-up in shortage areas that we aren't allowing I think is a fair question.

DR. LEWERS: When Craig mentions this whenever we get to geographic, we'll have to bring that back.

DR. WILENSKY: Yes.

MR. DICKLER: Madam Chair, Bob Dickler from the Association of American Medical Colleges. First let me compliment you on the depth and range of your discussion. It really was remarkable.

A very brief thought that may be helpful. You have often commented on federal policy and incentives. It is useful to distinguish incentives in the creation of training opportunities versus incentives in terms of what opportunities students access.

We have had a phenomenon in this country for a long time that we have many vacant training positions, have had, for instance, historically in family medicine, while we said we had a shortage. We did not have a problem with creating the training opportunities. We did have a problem with attracting young people into those training opportunities by making that specialty or primary care area attractive. You may find that an important distinguishing set of characteristics as you go through some of the policy options.

Thank you.

DR. WILENSKY: Loan forgiveness for their $110,000 in debt from medical school could go a long way to help that. But yes, I agree.

DR. ROWE: That's a good idea, Gail.

DR. WILENSKY: I agree.

Any other comments?

[Pause.]

DR. WILENSKY: We're going to switch now to outpatient hospital PPS.

DR. MATHEWS: Good morning. The first order of business is to let you know that the Health Care Financing Administration has extended the comment period on both the ambulatory surgical center and the outpatient hospital prospective payment system proposed rules to January 8th, 1999. What this means in a practical sense is that we could discuss this issue again in December if you really wanted to. In that case, I will have another letter ready to submit, one that begins, Dear Murray. Hopefully it won't come to that.

[Laughter.]

DR. MATHEWS: There are only a couple of outstanding questions that we need to resolve it, albeit they are somewhat large ones. But also keep in mind that you'll have another opportunity to refine your positions as we put together our March report.

I don't have too much of a formal presentation today. Rather, I'd like to use this time as an opportunity to discuss and resolve hopefully the remaining issues before finalizing the Commission comment letter on the proposed outpatient PPS.

To the best of the staff's recollection there were three major points that were left open from last time. These are the level of payment, including payment impacts and adjustments, a volume or expenditure control mechanism, and finally, consistency of payment across settings. What I'd like to do this morning is refresh your memory on these issues and facilitate your discussion of them in any way that I can.

As we noted last time, the BBA's outpatient provisions will result in significant reductions in payments to most hospitals relative to what they would have been paid under the prior law. These reductions result from the elimination of the formula-driven overpayment, the extension of operating and capital reimbursement cost reductions, and the way the outpatient PPS is planned to be implemented. We estimate that once these provisions are put in place, aggregate Medicare payments for hospital OPD services will be roughly 80 percent of their reported cost.

Further, the impacts of this reduction are not uniform across classes of hospitals. Low volume hospitals and certain specialty facilities are anticipated to experience greater percentage reductions in payments than other hospital types. Attachment 2 of your mailing materials shows the projected impacts in more detail.

While the intent of the BBA was indeed to reduce payments to hospitals, the magnitude of these reductions, especially for particularly classes of hospitals, may affect their ability to provide services to beneficiaries. At the very least, such constrained payments may hinder the migration of services from inpatient settings to less costly ambulatory ones.

Previously you've indicated that the level of payment should be sufficient to provide adequate and appropriate outpatient care to Medicare beneficiaries. In preparing a response the HCFA NPRM you may want to discuss the adequacy of this level of payment and whether or not these impacts should be partly or wholly mitigated by specific policies.

The next discussion topic is outpatient volume control. The BBA requires that HCFA implement a system to control the volume of hospital outpatient services under the new PPS. In the NPRM, HCFA proposes to initially use an expenditure cap to control the growth of service volume, which is consistent with your March report recommendation on this subject and in accordance with the BBA's direction.

HCFA believes that this method will not be reliable due to the instability of assumptions regarding service utilization beyond 2001. HCFA proposes several variants of the sustainable growth rate, or SGR system, used as a volume control incentive in physician payment.

Their preferred option is a hospital-specific SGR system due to the relative ease with which it could be designed and implemented. The other options involve expending the physician SGR to the hospital outpatient and all other ambulatory settings. These approaches have the advantage of not reinforcing what we're glossed previously as the silo effect, would be difficult to implement from both administrative and from policy perspectives and would likely be challenged for exceeding the mandate of the BBA.

At a previous meeting you requested additional information and further discussion time before addressing the issue in the comment letter. Attachments 1 and 3 of your mailing materials provide this additional information to facilitate your deliberations.

The last topic you may want to consider today is that of consistency of payment across settings. As we've noted previously there are major changes in Medicare payment policy taking place in most of the major ambulatory settings. To an extent, these changes are transpiring on relatively independent tracks.

The Commission has in the past expressed an interest in making more explicit connections between these separate policy areas, and the outpatient PPS presents an opportunity for indicating how you think this should be done. As a foil for your discussion of consistency, Attachments 4A and 4B of your mailing materials present some prior law payment simulations for cataract surgery and the corresponding payments that would be effective under the new systems that have been proposed.

Looking at these data one could ask which, if any, of these rates are the appropriate payment for the service? Are any of them? Are all of them? How can you tell? If they are appropriate, is it by design or

by accident? That is, can the logic that produced a correct rate in any of these cases be applied to other services and other settings and also produce a correct rate?

I believe these questions cut to the core of the meaning of consistency of payment and may provide a departure point for further analysis.

At that point I will end my overview and make myself available to facilitate your discussion on these and any other points you'd like to raise.

DR. WILENSKY: One of the things you may want to

-- does anyone want to on the slides, particularly the consistency, just to look at them or are there any questions? We went through this very quickly and I don't know whether people have any questions about the numbers that were put up there.

DR. LAVE: Yes, I have a question on the consistency one, on the next issue, on the 1991 one. I'm looking at your cataract example that you have here. I guess the question that I have, and this is a question that came up last time, has to come with the substitutability across these settings and what we want to say about that.

This popped to mind when I was looking at this cataract thing, and it turned out that the amount that's given to the hospital outpatient and the ambulatory surgical center are almost identical. But if it's done in the physician's office the total payment is $664. But I just don't know how often this is done in a physician's office so how relevant this is. So that's the question we talked about last time.

DR. MATHEWS: Right. Our claims show that it's done about zero percent of the time in the physician's office. On the other side of the coin, the highest rate for cataract surgery is in the inpatient setting. I think it's close to $3,000. And that also has a zero percent performance rate.

DR. NEWHOUSE: I guess the question is, how easy is it to re-label the ambulatory surgery or the office?

DR. MATHEWS: I suspect it's fairly easy, or it has been historically.

DR. NEWHOUSE: I think we need to find out the answer to that question. In fact, one of the things that I've kind of worried about is do you call the building next to the hospital the office building or the outpatient department. I think there's a single word that pops up in the letter of response that I think framed the issue for me. That is you say in the second paragraph, the Commission believes that neutral payment incentives could be developed most effectively by adopting payment policies that could be applied consistently across ambulatory settings.

My question was, how would I know if I had a neutral payment policy? I actually began, as I thought about I began to wonder whether we really meant neutral payment policy, because I would have taken neutral to mean that we would have paid marginal costs. The problem with that, of course, is (a) we don't know what marginal cost is; (b) it will vary by facility by scale. Actually you bring up that it varies by how busy the place is.

DR. CURRERI: Is there a difference between neutral payment policy and neutral payment incentives?

DR. NEWHOUSE: That's why I wanted to get to it, because I think what we mean or I think what the thrust of the letter is, actually it's not neutral but it's least cost. Or that we would pay at some rate and if this other site, it cost more in the other site then we wouldn't pay those costs. But maybe that's not what you meant.

I think there's an ambiguity that needs to be resolved as to whether if -- let's leave aside the variation within the facility type, that kind of small outpatient A costs more than large outpatient B, and just say

outpatient department A, suppose it costs more than the office or the ASC. Does the payment system recognize that cost differential or does it just pay a flat amount? And what's the principle that's governing that call?

DR. MYERS: Joe, if we should be doing marginal costs, are there ways for us to get closer to that?

DR. NEWHOUSE: I'm not sure there are. But even if you said we should be paying marginal, there's still an issue about do you want to pay marginal costs of the least cost facility? Then what if that's the below average cost so there's a loss?

But setting that issue aside, the issue I want to focus on, are we paying for the least cost site or are we paying for the cost of all of these different sites, whatever they turn out to be? And then there's a further issue about marginal average.

MR. JOHNSON: Joe, there's another factor here too, that all these patients and all these sites aren't necessarily equal either.

DR. NEWHOUSE: That's right, but I want to set that issue aside to focus on, suppose there are higher costs in different sites even for the same patient.

MR. JOHNSON: But as I said, all sites are not necessarily equal either. You may only be doing these kind of surgeries in the rural hospital because there's no ASC around or anything else around, and they may have additional costs to keep that facility open. Do we say, we take all these outpatient surgery patients and we don't pay those costs? Do we carve that out?

DR. NEWHOUSE: I think that's in effect how we backed into the cost-based system. I think that's a good question. I think we would still, however, as I say, have that problem within class because you would say, if you were paying one rate for outpatient departments that was an average over all outpatient

departments and there were economies of scale, which there surely are, the small rural would still have a problem.

MR. JOHNSON: But it seems to me this whole issue, when you read through the letter and the background material it's, on the one hand this, on the other hand that's really difficult. And on the one hand this, and then the other hand we don't really have the data to compare. On the one hand this, and the other --

I mean, this is obviously a policy that I would say at this point is based a lot on intuition. We went through this with Blue Cross in Michigan when hospital outpatient costs spiked a couple years ago. It's now down quite low. Hospital costs overall are less than the growth of the other areas.

The fact is, we need more facts here, because a lot of the solutions here that we're proposing are untested or complex, and I think they're going to have some fairly detrimental impacts on certain classes of facilities. I don't know, I'm just very uncomfortable with this whole thing.

MR. MacBAIN: I think when we talked earlier about this we were talking about neutrality in the sense that we didn't want the administered pricing system as it develops to influence the site of care, which means that focus would have to be on that how that choice of site was made, who made that choice, and on what basis.

Conceivably, you could argue that if it's the physician making the choice of the site of care then the issue should be, what is the difference between the physician's marginal revenue and marginal cost for that particular procedure, which is not the kind of thing we're looking at here and would not look at the overall cost to Medicare. But that may be really what we want to focus on.

Another thing that concerns me in looking at this is that our analysis is perpetuating the silo phenomenon. Particularly with the low volume rural hospitals I'm concerned that we have simultaneously or nearly simultaneously changes in hospital outpatient payments in facilities that are heavily dependent on both

their outpatient revenues and their Medicare revenues, along with changes in skilled nursing facility payments for facilities that have swing beds and dedicated SNF beds. And along with those changes in payments they're now responsible for a hefty chunk of ancillary costs.

Then on top of that we've also got the change in the physician fee schedule for the work component, and among the specialties hardest hit there are emergency medicine, pathology, and radiology, which is also going to have an impact on small, low volume rural hospitals.

If we're going to comment on what the impact is on rural hospitals, I think we need to take a look at the combined effect of all of these and take a more horizontal view. And add into that as well some analysis of how do these hospitals do as well on their inpatient PPS margin and their overall margins. Because if we don't do that, I think if you look at each individual component by itself we may say, that's bad but it's not so bad, and when you add it all together we may end up with a serious access problem.

DR. ROWE: A couple comments. I may just be reiterating what was said before I returned. But with respect to the letter to HCFA on this, I gather that some analyses were done that looked at the impact of adding a teaching or DSH consideration with respect to this on the teaching hospital side which mitigated some of these changes, but HCFA decided not to go ahead and include that and our letter is silent on that issue.

DR. WILENSKY: I don't think I'm understanding your point.

DR. ROWE: I guess there was some considerations in HCFA in their analysis that there were additional costs associated with GME or in DSH hospitals in the outpatient facilities which would change some of these numbers in major teaching hospitals, but that because of their lack of certainty with respect to the data they just decided not to include those adjustments in the PPS in their suggestions. Lack of absolute certainty with respect to the data hasn't always prevented them from making adjustments in the past. It may be the only data we have.

I gather we were silent on that issue, which is fine. But I just wondered whether it was discussed at all by the staff and whether we have any information on it or not.

DR. MATHEWS: I'm not aware of the specifics of any modeling that HCFA did internally and they didn't report the results of the modeling on those classes other than to present the impacts straight up. We felt in drafting this letter our best approach would be to address the issue of the need -- point out the impacts and address the need for adjustments in a general sense. We can focus our own analyses on classes of hospitals that you feel there might be some legitimate basis for these higher costs.

DR. ROWE: I was talking with Joe earlier and he recalled some studies that seemed to indicate that there were some higher costs, at least on the teaching side. So we might look at that and see if it pans out. If not --

DR. MATHEWS: We did, in developing our own payment model here, confirm the fact that hospitals do have higher reported per unit costs for services across the board. The question is, what do you do about it? We have not come up with a specific proposal in this comment letter.

DR. ROWE: Exactly. The second point relates to Attachment 1 and it's just in the interest of neutrality. I've heard neutrality a couple times in the last couple minutes. We hear all the time, we talk all the time about the positive margin of teaching hospitals on inpatient PPS, and it's X percent, 1 percent, 2 percent, whatever.

It's really interesting here because what we say under impacts on the first page of the attachment is, we talk about the predicted .78 payment to cost ratio and we say, is this a real threat to hospitals or is it simply an artifice of hospitals' accounting and Medicare payment policies? But when we report the inpatient margin as positive we never say, is this a real benefit to hospitals or is it just a artifice of hospitals' accounting and Medicare payment policies.

So I think we should probably include that statement in there. We should be more balanced.

DR. MATHEWS: These attachments are not intended to be part of the letter that we'll transmit. This was just for your --

DR. ROWE: Good. It reflects a point of view, that's all.

DR. NEWHOUSE: Jack, I was thinking a bit about your comments on DSH and I would have said for myself we probably should consider that as part of an overall recommendation on DSH if we're going to do it and not kind of separately. I would also -- it occurs to me that the current DSH formula, as you know, favors large urban hospitals. So it's not clear to me how things come out, but I think we should discuss it in the abstract anyway. But part of an overall discussion of DSH rather than as part of the outpatient system.

DR. MATHEWS: At the staff level we are doing some modeling relating hospitals' DSH percentage to potential outpatient payment adjustments, but we don't have anything ready to go.

DR. NEWHOUSE: Speaking of DSH, by the way, on our next discussion of GME I think we should take up the issue of whether DSH should be considered along with -- as part of the basis for setting the indirect medical education payment or not. But that can be left until next time.

DR. WILENSKY: I'm unclear on the comment about neutral that was raised. In the letter itself the term neutral is used without further clarification. Was it being proposed, since people have used the term in different ways, that we specify what we mean by the term neutral? We have something that indicates policies that can be applied consistently, but not really defining --

DR. NEWHOUSE: I was going to leave it at that. But maybe other people may not agree.

DR. LAVE: There are basically two different issues here and they're not the same issue. One issue is the choice of setting, the other is the least -- one has to do with appropriateness, and there are two types of appropriateness. One type is the medical -- there are two types of appropriateness it seems to me.

One of which is sort of a clinical or a medical appropriateness issue. That is, where is the -- is there a setting for which it is more clinically appropriate to treat the patient? The other is, is one site more appropriate in an economic sense? Is there a site for which in fact it's more efficient to treat the patient?

We may want to indicate that those are two different things. Because if I think of appropriateness, if I read this, I would think of it in terms of a clinical decision as opposed to a costing decision. I'm coming back to your initial discussion.

So we may want to say that our comments are, we don't want the payments to be -- lead to inappropriate clinical decisions, and we would like them to lead to appropriate economic, efficient decisions. I mean that's sort of -- and it doesn't necessarily say to do that that you have to have the same price, but that's really where you're going and that may basically be sufficiently vague.

And then get rid of the rest of this stuff and then come to the next paragraph, because you know, I think we've argued before it's not clear that we know how to do one or the other, but we can certainly figure out on the direction in which to get there. And I do think that there may be a clinical issue in here as well as an economic issue and that they both should be raised.

I had thought that one of the thoughts that we had in terms of the consistency was that there was an issue of consistency that had not to do with sort of the -- an economic issue in terms of appropriateness, but rather in terms of the fact that -- consistency in terms of policies that made sense in terms of the way they got together. That you called a spade a spade, as it were, regardless of the setting in which you were in. So you would like -- and eventually they're all going to move in the same direction, but not quickly.

DR. NEWHOUSE: I didn't follow that last --

DR. LAVE: You know, when we first talked about consistency, I thought that what we were talking about was that you didn't want to define -- and this comes up later in the argument -- that you didn't

want to basically have something -- the basis of paying for X different in one setting than in another setting. And to the extent that you could sort of define these things similarly in terms of the unit of payment that you were being consistent. And that's -- I also thought that we were talking about consistency in the outpatient department in that respect as well.

So you had sort of a consistency in that if I am paying for the cup in setting A, I'm not going to pay for the cup plus the water in setting B, and the cup plus the water plus the ice in setting C. That in each of them I'm going to pay for the cup and the water. Does that make any --

So I thought that that was sort of the consistency argument. And we were having the same argument with respect to some of the post-acute care, that we wanted our definitions to be consistent across these settings. So I think we have sort of a definitional consistency in terms of the unit of what we're paying for, and we would like to sort of think of our decisions as leading to clinically appropriate decisions as well as economically efficient decisions.

DR. ROWE: But, Judy, as I recall that discussion, the clinically appropriate piece of it was not so much that we're paying for the same thing in two different settings. It's like we're paying for your having that little operation on your wrist and it's the same operation on the wrist, so regardless of where it's done it should be paid the same.

I thought the point that was made during the discussion was that if you're a healthy young, or middle-aged health economist and you need one of those little fasciectomy, you get sent to the ambulatory surgery site. But if you're an 87-year-old demented diabetic in heart failure on six medicines with that thing, then you get sent to the ambulatory surgery clinic at the medical center.

So while it's still the same thing, there's a lot more to be done to handle patient two than patient one.

DR. LAVE: Okay, but that has to do with -- but we're still defining it differently and that's where the issue of clinically appropriate came in in terms of this definition.

MR. SHEA: You'd support that, right?

DR. LAVE: I would support that, yes. But we'd like to know that you're talking about this same --

DR. ROWE: About the same thing, but in two different --

DR. LAVE: Right.

MR. SHEA: But that definitely -- I happen to agree with Judy, that definitely should be not uniform pricing.

DR. NEWHOUSE: That's right. But then the issue is, so then how do you prevent everybody from shifting over to the hospital?

DR. LAVE: But the problem has to do -- we don't observe that happening now.

DR. ROWE: Yes, it seems to be going in the other direction.

DR. WILENSKY: Let me just -- I'm concerned that we're giving HCFA guidance about what we don't want and we're not doing a very good job about giving HCFA guidance about what we do want. And having some sympathy with the operational problems of running these payment systems, that doesn't seem very helpful.

Are you thinking, Judy and Jack, that what we need to do for CPT codes is to do something like what we do with the DRG, which is there is at least a different DRG based on complicated or uncomplicated? Something that would allow for the fact that the procedure itself, subject to comorbidities, is effectively a different procedure and therefore -- or associated with different costs.

I just feel a little uneasy. I think that the general principle we're articulating is clear enough, but I'm not sure --

DR. CURRERI: I thought that what we were looking at here was a bundle, and it was a minimum bundle. It included laboratory tests and so forth and so on, and that extra things for extra ill patients were billed in addition. Am I wrong about that?

DR. WILENSKY: The problem I think that was being raised is that we bundle it only in the outpatient and if the same procedure is done in the physician's office it's unbundled and that that was really -- to the extent that that happened and it was indeed the same procedure, we were asking for trouble basically.

DR. CURRERI: But I thought that what we were aiming for was a bundle in the office, too. So that the bundle would be the same, and then the physician could choose the most appropriate area because there wasn't any financial incentive.

DR. ROWE: But the services, this bundle is going to be the same in both places because the added burden, which is added cost is extra personnel or this or that, but it may not be something that's definable as a specific service is, I think, Gail's point. So the bundle may not be different.

DR. LAVE: I guess, if you think about all of these payment sources we've evolved them over time. We don't try to get them perfect the first time. So it seemed to me that the first thing is that we'd like the bundle to be the same, so it is the same in the physician office and it is in the hospital. We would like it to be cheap and we would like it to be appropriate.

Now what information basis do we have now? We can certainly make recommendations that the bundling proceed apace so that you have the same unit in the physician's office and so forth. That seems to me to be relatively concrete. It strikes me that with respect to whether or not the hospital and the ASC are

different, that one in fact might sort of think about whether or not you may want to do a bump-up. I mean, we do that for other things. It doesn't strike me that if in fact -- or we might be cautious about recommending --

I mean, as I indicated last time, I'm uncomfortable recommending identical payments across these sources because the costs now look to be so different that do you want a cautious -- do you want to be risk averse with respect to being economically wrong, or do you want to be risk averse with respect to being clinically wrong. Those are what the two decisions are that in fact you have to make, and people come down very differently on those two issues.

I think that that is one of the things that may be coming up on this teaching hospital thing, that we could express it as a concern of ours and make some suggestions, if we have any as a commission, that we would like to see things go. If not, raise it.

But I think to assume that the patients are identical may not be the appropriate decision to make, given as I think we've all observed anecdotally, allocation decisions be made about where given patients get treated and some of them are consistent with more complicated patients ending up in outpatient sites as opposed to physician's offices.

DR. NEWHOUSE: Am I right that we don't have the technology to identify at the moment more complicated -- follow Gail's suggestion?

DR. LAVE: Yes.

DR. WILENSKY: Does somebody have an answer to Joe's question? Assuming that we don't have an ability to distinguish the more --

DR. MATHEWS: We have a project in progress right now. I'm optimistic we can get the results of it to you in January, which looks at patient characteristics for beneficiaries who receive the same benchmark services in different settings. We looked at where they live, comorbidities and coexisting

conditions, age, income, we're looking at. So we should be able to give you some quantitative information for a few selected high volume procedures.

DR. WILENSKY: That would be very helpful.

DR. ROWE: But that will be too late for our response to this.

DR. MATHEWS: That's correct. You could maybe squeeze it into the March report as a recommendation.

DR. WILENSKY: But I think then we just need to be comfortable that the sense of the direction is adequately reflected in the letter. That this is where it needs to go, and we're doing work on this, and HCFA needs to do work on this.

DR. ROWE: You would support, Gail, if I understand you, including the letter language that indicates that we think that there should be some adjustment or consideration with respect to this and leaving it at -- and that we're doing work on it and they should do work on it?

DR. MATHEWS: That's correct. On page 6 of the letter where I talk about adjustments, there is a specific reference to adjustments being made insofar as they reflect where it can be tied to patient characteristics.

DR. CURRERI: Are we really talking about differences in facility costs or are we talking about differences in patient severity of illness costs?

DR. WILENSKY: Right now what we're talking about -- we might talk about the latter.

DR. NEWHOUSE: The latter is affecting the former.

DR. WILENSKY: The former. Right now we're really talking about the latter. The fact that if you have the people who go into the hospital outpatient typically with more comorbidities or a higher severity or other --

DR. CURRERI: We talked about a bump-up. The problem with a bump-up based on facility is that is --

DR. WILENSKY: It's very crude.

DR. CURRERI: But you could have a bump-up based on patient severity, and that may be the way to go.

DR. WILENSKY: Right.

DR. ROWE: The letter says patient characteristics.

DR. NEWHOUSE: That's where we're headed.

DR. WILENSKY: That's where I think our preference is, that we make it tied to the patient since we know from past activities the correlations when you tie it to facilities tends to be pretty messy.

DR. ROWE: What it says is it's the former's -- in your question, it's the latter's influence on the former. It says, we believe there are qualitative differences in the services provided that reflect characteristics of the patient that are different. What we don't say is, we think that there should be a payment to reflect these differences.

DR. CURRERI: But you could have some sort of a code that reflected patient severity.

DR. WILENSKY: That's what I meant.

DR. ROWE: So I think what Gail is suggesting is that we say something to say that we think that we should recognize --

DR. WILENSKY: Right, we think that's the direction it should go.

DR. CURRERI: I just don't want to see a facility difference --

DR. WILENSKY: I understand and I agree. I don't think having --

DR. CURRERI: -- because that's a big problem with gaming.

DR. WILENSKY: And we can be very clear.

DR. NEWHOUSE: It would lead to a difference in the facility payment but would be based on the patient characteristics.

DR. CURRERI: Yes, that's right. But I don't want it based purely on what the facility is.

DR. ROWE: People would be building facilities because they get paid by facility as opposed to the services that are provided.

DR. LAVE: But there's an issue, and the issue is the following one. Do we -- you can have -- as I understand this, there is no phase-in and out. This is in and there's no transition in the outpatient PPS; isn't that right?

DR. MATHEWS: That's correct.

DR. LAVE: So there is not -- I mean, almost everything else that we have done we have had some form of a transition period. So I think the question is whether or not, given that one observes that the facility costs are considerably higher than the other outpatient setting costs would one want to have a mild facility payment? Because we can't do a patient payment right now. That's impossible.

So the question is, in the interim should there be nothing, or should there be something?

DR. WILENSKY: You know if you put in a facility bump-up you will never get rid of it.

DR. LAVE: Well, you could phase it out. We phased out all the other stuff and it went out. We phased out national -- we phased out the hospital -- we have phased out higher costs over time in almost -- we're doing it in nursing homes and we did it in hospitals.

DR. WILENSKY: But not by -- we phased out higher payments as a class, not by having this bump-up. That's different. If you want to slow in the adoption, that's one thing. Putting in what you think

is going to be a temporary bump-up just flies in the face of all of our experience. I think that is not a good way to go.

DR. ROWE: What do you think, Joe?

DR. NEWHOUSE: In the short run? I mean, the long run seems --

DR. LAVE: The long run is obvious.

DR. WILENSKY: You can think about it and let me go to Bill.

DR. NEWHOUSE: We have a de facto difference now and maybe that should be phased down somehow or maybe continued. I have to think about that.

DR. KEMPER: But did I understand right, on the cataract table, that's the payment that will be without a change, right? That's the way the payments will be made is in the way that --

DR. MATHEWS: No, the one that was on the overhead are current law simulations. But you also have a proposed law, I believe it's Attachment 4B of your handouts.

DR. KEMPER: But it looks very similar.

DR. MATHEWS: It does.

DR. KEMPER: So in a sense, there is already a facility bump-up.

DR. MATHEWS: That's correct.

DR. KEMPER: It's not called that, but it's in there.

DR. WILENSKY: Right.

DR. KEMPER: So we would have to make a recommendation not to do that in order for there not to be a differential payment across settings.

DR. LAVE: That's across settings, but that's not across all hospital outpatient departments.

MR. MacBAIN: I'm getting a little lost on this I guess, but is the payment to the facility the relevant issue if we're concerned about how the decision is made where a service is performed? Or is it just the payment to the physician and the relationship between payment and cost to the physician in different settings?

DR. WILENSKY: I think it gets to the issue that Joe raised that we're not sure we can always identify a physician's office building and ambulatory setting and an outpatient because you have these things that are next to hospitals that seem to carry different names. And if we make it substantially different in terms of the economic payment, economic incentive, we're likely to find the naming follow rather than the otherwise --

DR. NEWHOUSE: It gives new meaning to the term, naming opportunity.

MR. MacBAIN: It's substantially different now, so what we're talking about is -- the difference is already great enough that a lot of that should have already happened.

DR. WILENSKY: Right.

MR. MacBAIN: So now we're talking about backing away from it and I'm concerned if we do that, assuming that the hospital outpatient, which is the most expensive alternative, is the predominant alternative -- and a lot of communities don't have the alternative of having the services moved to an ambulatory surgical center -- that all we're really doing is finding a way of reducing the payment. And that could be done in a way that causes some real harm to hospitals.

DR. KEMPER: I just wanted to pick up on what Gail said about useful guidance. It strikes me that this is an area where we really need to do some more work over intermediate or longer run to be useful. I mean, I think the basic principles we've been articulating about silo effects and so on are very useful.

But I think what this underscores, and particularly just throwing up the slides of what the payments are, that translating into something useful and into really payments requires both a clearer articulation

of the differences between clinical differences and cost differences and so on. And then actually some thought about how one would actually develop such -- equalize those payments and get rid of the setting disincentives, at the same time ensuring that the more complex patients were treated in the outpatient department or where they should be.

That's going to come over and over again as how to translate the general principles into something practical. So it also becomes not very useful guidance at the general level we're talking about. So I don't know how that plays into the workplans, either for this year or subsequent, but it seems to me it's important to push it further to be useful to them.

MR. SHEA: Jim, just could you clarify for me to what extent HCFA and we are talking about bundling here? Because we've been referring to this as a bundled unit. I thought I read the draft letter as saying this was only partially bundled, because there was a decision not to include certain services for a variety of reasons.

DR. MATHEWS: That's correct. The bundle of services that HCFA has proposed here is more or less consistent with the bundle of services that is currently paid for under the physician fee schedule and the ASC rate. There are slight differences between the facility payments and the physician payment in terms of the actual goods and services covered in the bundle, but this is close, and I think we can resolve any other differences.

The question in the future is whether or not to expand that bundle to include other ancillary services that are currently paid separately and could continue to be paid separately into the future.

MR. SHEA: What's now outside the bundle in the current definition?

DR. MATHEWS: Under the proposed definition here things like laboratory, x-ray, EKG, ultrasound. Things that would ostensibly be related to a major service or procedure still in and or themselves can be a reason for a visit, if they are referred ancillaries and they can be billed and paid independently.

MR. SHEA: That's true across all settings? They're not included in the hospital outpatient and excluded in the physician office?

DR. MATHEWS: That's correct.

DR. WILENSKY: Now are we suggesting by virtue of our earlier discussion that our recommendation would be for HCFA to concentrate first and us, to the extent we can be helpful, on trying to do clinical or severity differentials rather than trying to figure out how to expand the bundle?

It seems like from what we've said that our sense would be, rather than figuring out the bigger bundle, think about how to differentiate clinically for payment purposes people who use one setting versus another. So that if we have comorbidities or age associated with procedures we will pay appropriately. If it happened that they went to an ASC or a doctor's office, we want to pay them more. If they happened to go the hospital outpatient we want to pay them--

DR. ROWE: That would decrease the risk of getting services that you don't need, just because they're going to get paid for it, right? I mean, that's the idea.

DR. WILENSKY: Or getting payments that don't reflect the actual services that are used, which is more likely.

DR. ROWE: That's right, yes.

MR. SHEA: I think that's right. I think we should just be cognizant of the fact that there's another piece of this. Maybe it's not one that we've ever address, or maybe financially it's not all that important. But it doesn't sound minor, in any case.

DR. WILENSKY: But it does seem -- I mean, again to the extent that we haven't -- I don't know whether we've made that point clear, but that would seem to me, again, just at least giving guidance and also could be guidance for us.

DR. LAVE: Can I raise another issue about this clinical thing?

DR. WILENSKY: I have Joe and Bill Curreri.

DR. NEWHOUSE: I wanted to turn to the SGR issue.

DR. WILENSKY: Bill, did you have a point on this issue?

DR. CURRERI: No, it's not on this issue, so go on, Judy.

DR. LAVE: My point is on this issue, and that is that whether or not we can give guidance about where to look for this stuff. Because I find this whole area terribly complicated.

But the outpatient department, I mean you go and you get an x-ray. I'm assuming we wouldn't think that an x-ray is more complicated in an older person than a younger person. And we go and get lab tests. I mean, there are lots of things that we go to get that one would not think would affect the patient severity issues -- might not forget that.

So if you're going to worry about a patient's severity classification, where should you look? I mean, I think that's one of the things that we have to realize is --

DR. ROWE: Just clinically I think that's wrong. Judy, I can go --

DR. LAVE: I don't know. I raised it.

DR. ROWE: I can tell you to go up, I want a chest x-ray. Stand against a wall, take a deep breath, don't move. Whack, you're done. Then I can take an 89-year-old demented woman and tell her, stand up against the wall, take a deep breath, don't move, I'll take your x-ray. That's not the way it works.

I have to have somebody get her there, somebody hold her, do it two or three times. She moves, she breathes. I mean, it's just different.

DR. WILENSKY: But in fact it's not an issue because it's not part of the bundle.

DR. ROWE: Exactly.

DR. LAVE: But it is part of the -- but there is an outpatient rate for an x-ray.

DR. MATHEWS: That's correct.

DR. WILENSKY: For an x-ray. But it's not part of the bundle.

DR. MATHEWS: Right.

DR. WILENSKY: So it's a separate --

DR. LAVE: But you see it does have -- but it comes to the issue of what we're talking about. That's why I explicitly raised this issue, and that's why, you know -- is that we really -- you have a whole bunch of services, all of which are being paid a fee schedule. And we have -- and the fee schedule is the same regardless of where this is done.

DR. WILENSKY: But the site isn't the issue. Again, you're saying outpatient --

DR. LAVE: But the question is, when we're giving direction to HCFA about who they should be studying, to who they should look more expensive, if we take Jack's example, that is not something you're going to be able to look at by looking at the claims data under a fee-for-service setting, because that has to do with a very different kind of resources which are being used for those patients.

So I think it's very important to try to figure out where you think the problems are going to arise with different kinds of patients so that you then go look to see about how in fact you would conduct a research project. Because to take this x-ray, all that's going to come up in the claims data in Jack's example is

an x-ray was done. There is nothing that's going to come up that says, if this is true, there was an escort, there were two people holding her up. None of that is going to show up, but it's going to show up in the --

DR. WILENSKY: George, did you want to say something to respond? I think the common work file might tell you that information.

MR. GREENBERG: I'm George Greenberg and I work at HHS and ASPI. I've worked on outpatient issues for a long time and it seems to me there are some fundamental questions here as I think of them and I'd just like to share this, if I can. One issue in outpatient right now is Congress mandated several fee schedules. There are around five of them. There's ESRD, there's clinical lab, there's therapies. I can't think of five off the top of my head -- ambulance. And then we have this rest that will be paid through the proposed APC categories.

One big issue for the future is, do you want to, when you talk about the future bundle do you want to -- you know, the lab fee schedule is a level playing field. Do you want to incorporate that in the future in the bundled system? And then do you want to apply that to the physician system, which is one way to go. And there's a possible interregnum because I think the application to the physician offices may take some time.

Or do you want to continue to extend fee schedules into the outpatient settings and use the APCs to pay what isn't on a fee schedule basis? And there are merits on both sides of that question.

You can always have a hospital bump-up to the fee schedule if you believe that the backup capacity and the emergency room capacity is part of what the current higher cost that Jim mentioned is warranted. Or another alternative is to reallocate the overhead, because these are all allocated costs that we're talking about, to specifically pay. You know, the emergency rate -- if you had a fee schedule for radiology as well as lab, it may be that you've got to pay the emergency room and the other parts $300 a visit because that's the true -- because you've allocated the overhead back.

The other issue in doing the bundled payments is the redistribution that the APCs create among hospitals. I gather the AHA and others are doing studies of that. But if you're going to do APCs in the OPD setting, which is the way HCFA is clearly going, and you don't do it in other settings, is that amount of redistribution which is created even by the limited bundling warranted and what problems does it create, and what differences does it create, at least in the interim? So these are the intellectual questions.

The other question that I have has to do with the difference between resource costs and allocated costs. There have been several studies, some done by ProPAC in the past, that look at the resource cost for outpatient services. And I've done some work with Henry Miller who I think has done some of the work for ProPAC and for HCFA. And the surprising finding in each of these studies to me is that the resource costs in the hospital outpatient department in many cases are lower than for the ASC. That's a surprising finding. I mean, there's a lot of reasons for that. I won't go into it.

But one of the issues is that hospitals have been unbundling overhead from the inpatient department to the outpatient department for 15 years now. So when Joe raises the question about consistency of payment and Jim gives you these charts, are we looking at artifacts of a cost allocation system or are we looking at true costs of delivering the service? Which I think we really -- for Judy's comments about an efficient delivery system, we want to look at the true cost.

I'll stop now. As Judy says, this is a really complex area and just laying it out as I think -- I was just trying to help organize some of the points that were made into some broader questions. But I think the questions that must be resolved for the larger system one way or the other is, are we going to go in the direction of bundling more, which the APCs take you?

Sort of not -- and incorporating ultimately the current fee schedules into those bundles? Or are the fee schedules which currently exist, should they be kept and possibly expanded to some other services?

I think that's a fundamental choice and it really gets into this notion of level playing field. If the Commission could give guidance on that issue, it would be terrific.

And the other is then the resource cost versus the accounting cost when you talk about level playing field.

Then the third is, if you pay on a fee schedule basis, you can have a hospital bump-up, you can have a bump-up for severity, but what do you -- and if we're talking about true cost, then how do you keep the hospital whole? Because a couple people mentioned the notion that the hospital might be damaged if you pay a certain way on the lowest. And I don't think that's the goal. The goal is to give efficient price signals for these services. Again, those price signals should be clinically neutral.

DR. WILENSKY: Let me reiterate the point I made earlier. I think what I heard the commissioners saying that our advice with regard to -- thank you, George. It was very helpful. With regard to this issue about which direction we suggest HCFA move next, we would prefer to go in the direction of more distinction to the existing bundles so that we know if we have clinically diverse bundles in the bundles we have, rather than trying to make the bundle bigger, at least as our next step.

We can decide later -- if that's a correct assessment, we don't have to make the decision now, do we ever think they ought to do bigger bundles?

DR. NEWHOUSE: I think we disagree with going with the APC for the outpatient department and Medicare fee schedule for offices. I think that was where we came -- that's how we came into this discussion.

DR. WILENSKY: Right.

DR. NEWHOUSE: We don't really say that, I think, very cleanly in this letter, and maybe we need to say it cleanly. I think, George, that was very helpful. I think we need to probably say something on two other issues at least that he brought up.

One was that we'd like to know something about difference in resource costs, and that would require study. We clearly can't know that now. And if it's right, and I believe it, that the resource costs are less than these allocated costs we're looking at, then there's going to have to be an issue about how to keep the hospitals whole with respect to overhead costs, or fixed costs, or whatever we want to call them, that have been allocated. Those costs are real costs and have to paid somehow.

Then there's the issue that, I think on what George has called the fundamental issue of extending the fee schedule further. Where we came down last time was consistency without really saying -- kind of deciding the question of which way we were going to -- which schedule we were going to make consistent with which. I'm not sure we're in a position to do that now, although it sounds like we are headed more in the direction of the physician office -- the more disaggregated payment rather than the more aggregated payment. But I'm not sure about that.

DR. WILENSKY: And I don't know that at the moment we have to make that decision.

DR. MYERS: Question. You mentioned doing a study. Do you think it would be a good idea to do a cost accounting type of a look on the various resource inputs by setting?

DR. NEWHOUSE: I guess I need to know more. I mean, Judy was -- this exchange we just had about what's in the bundle and does the bundle really cost more? The answer to your question may be, it does depend on what's in the bundle. Say if it's supplies, supplies probably don't cost more. Space costs? I mean, I'm willing to buy the notion that ASCs cost more than hospital outpatient departments. It ought to cost more to have a freestanding facility than use existing space in terms of resource cost.

DR. MYERS: But do we need to know that multiplier? Would it be helpful to get a baseline there?

DR. NEWHOUSE: I'm a little reluctant to go that route personally because I think these facilities probably differ a lot within themselves, and to sort out kind of cost allocation of each hospital's accounting system sounds like a nightmare of a study to me. But maybe -- I mean, we are setting prices. I agree with George's statement, we're trying to set the right price signals, and if those signals are way out of whack with costs then we've got problems.

DR. MYERS: Does HCFA routinely do this at all? Does HCFA routinely look to see whether or not the --

DR. MATHEWS: They have in the past. I don't think it's a matter of routine.

DR. MYERS: In the distant past or the recent past?

DR. MATHEWS: Late '80s, early '90s.

DR. MYERS: That's distant past. I mean, I'm not an accountant or an economist, but it seems to me that every so often you want to check to see whether or not your approach is making basic sense. Maybe I'm alone in that regard.

DR. NEWHOUSE: You got one vote down at the end of the table for basic sense.

DR. KEMPER: Just two issues to add to this longer run analysis. One is the geographic issue of we're all thinking about cities where all three options might exist, all three settings might exist. But in rural areas they're not there. So what's the implication of that in terms of setting and payment, patient condition aside.

The second issue is if we're trying to set the right price signals, I think somebody mentioned before that the physician payment is different from the total Medicare payment, and we shouldn't think -- since

the physicians are mostly making the decisions, some thought needs to be given about who's responding to what signals in terms of the payment.

DR. NEWHOUSE: We have to come to the sustainable growth rate, too. But in terms of rural area, just kind of for my own information, am I right in thinking that, let's suppose there's one facility where this is done and it kind of sits there next to the hospital. Is there a constraint on what that's called?

DR. CURRERI: Well, it has to be licensed.

DR. NEWHOUSE: I understand. But can I call it the outpatient department, the office building, or the ASC?

MR. MacBAIN: You could probably call it the outpatient department. It would operate under the hospital's license.

DR. NEWHOUSE: Right.

DR. CURRERI: Because if it was an ambulatory care center you'd have to have a separate license.

DR. NEWHOUSE: And I could clearly an office building, right?

MR. MacBAIN: That depends on the jurisdiction. You could not in New York state.

DR. NEWHOUSE: Why couldn't I? You can't build an office building in New York state?

MR. MacBAIN: For a hospital to do it I think you'd have some problems.

DR. NEWHOUSE: I can sell it off to my physicians groups.

MR. MacBAIN: Yes, you could do that.

DR. MATHEWS: Joe, there are existing statutes listed in the Code of Federal Regulations that list some criteria for an ambulatory surgical center to be certified as such for the purposes of Medicare

billing. In the past they have been a little bit soft, and part of this proposal here does refine and strengthen those criteria that you need to distinguish --

DR. NEWHOUSE: How would that bear on this notion that if something I was calling the outpatient department I could re-label as the ASC?

MR. MacBAIN: Why would you though?

DR. NEWHOUSE: I probably wouldn't. I only would if it were to my advantage.

DR. WILENSKY: I'm looking back at our letter and it does actually -- the only negative is that we are not giving a whole lot of guidance to HCFA other than saying that having these payment systems consistent is important, and ideally, some measure of clinical differences. But we're not giving them a lot of guidance beyond that.

DR. ROWE: Can we get a copy of the next draft? Is the letter going to be sent before we have our next meeting? Because they extended until January, right?

DR. WILENSKY: We're meeting in December. You can see the copy of the letter before it goes out.

DR. ROWE: Great.

DR. CURRERI: I'd just like to say that this letter is vastly different from last month's letter and I think it's important. I'd like to congratulate Jim for actually reflecting very, very well what the Commission said at its last meeting.

DR. MATHEWS: Which is different than what's happening at this meeting.

[Laughter.]

MR. SHEA: So we're really looking forward to the next draft.

DR. CURRERI: The reason I say that is that the things that have been controversial today were issues we didn't deal with last time. I just want you to know, I thought you did a bang-up job in reflecting the Commission's discussion last month.

MR. MacBAIN: There is another positive recommendation in there and that's to somehow consider the impact on low volume hospitals, especially rural hospitals. I think that needs to be underscored, for the reasons I mentioned earlier, because this does not happen in isolation but happens with some other things that are simultaneously decreasing income to the same institutions.

DR. NEWHOUSE: I think this is still murky, at least in my mind, in terms of answering George Greenberg. But let me turn to the SGR issue because I think to say that we favor an SGR that is hospital outpatient department specific seems to me that we are saying that we know something about how procedures are going to shift back and forth between sites, and I am very uncomfortable with the SGR at a very specific level.

I mean, it's one thing to say kind of the cost of the overall Medicare program ought to bear some relation to GDP growth. It seems to me another thing to say that each little component of the Medicare program needs to bear some relation to GDP, and to bear the same relation to GDP growth as every other program. That would freeze technology. So I think the SGR needs to be applied broadly.

I think we probably should come back at a later point and grapple with the issue of kind of why the SGR is or ambulatory services and we have a different system for inpatient services. But that's for another day. But at least we ought to keep it as broad as possible.

MR. MacBAIN: The other issue that I raised yesterday too with regard to sustainable growth rate, and that is trying to adjust it for changes in enrollment into or out of various Medicare+Choice

plans, which gets back to where you ended up of let's look at the overall growth rate and per capita Medicare cost relative to the rest of the economy without breaking it down further than that.

DR. KEMPER: I had the same reaction of wanting the broader cap. But I guess I wonder, Jim, whether you had done any thinking about what that meant in terms of future implications for the payment in the various sectors, in the various sites. What does it mean? Would it then just be driven totally by physician payment and this would be -- it really wouldn't be binding on, it really wouldn't have much effect on where these procedures were done?

DR. MATHEWS: There would be a single ambulatory update that would reflect changes in the provision of services and GDP specifically related to all settings that we would define. They would all float together to the extent that --

DR. CURRERI: But how would that deal with the shift from inpatient to outpatient?

DR. NEWHOUSE: That's the issue that we've got to deal with at a later date.

DR. CURRERI: That's what you're saying, that if there was a massive shift one way or the other you'd have a problem from year to year.

DR. NEWHOUSE: But that's true now, Bill. There's a big shift into physician offices.

MR. GUTERMAN: One way to approach the issue might be to have an update framework where you consider increases in resource costs in the outpatient setting and then have an adjustment factor for either appropriate or inappropriate switches, you know, shifting from one setting to another, if you're interested in controlling it on the setting level.

DR. NEWHOUSE: I don't think we know enough to do that, to say what's appropriate and inappropriate. I would rather, I think, just set some overall caps that would be fairly broad and let the medical delivery system sort it out.

DR. KEMPER: Broad in the context of this letter is different from broad in the context of what you're saying. You're saying much broader for the Medicare program as a whole.

DR. NEWHOUSE: Yes, but that issue can't be dealt with in this letter.

DR. KEMPER: I understand that. I'm trying to get -- in this letter, HCFA really would rather have a very specific and narrow cap. And if I understood the sense, we're saying, no, it should be a broader --

DR. NEWHOUSE: But the letter says it would be difficult to implement, and I confess I didn't see why it would be difficult to implement.

DR. WILENSKY: A broad or a narrow?

DR. NEWHOUSE: Broad. Well, either. I didn't see why it was --

DR. WILENSKY: It's difficult to implement a broad unless you have some guidance about if you exceed the cap what you do about it.

DR. NEWHOUSE: You're subject to -- then, you know, the system kicks in and you --

DR. WILENSKY: Would you just do proportionally?

DR. NEWHOUSE: Yes.

DR. WILENSKY: I think that we certainly can say that it --

DR. NEWHOUSE: Let me put it another way. That seems better to me than -- suppose you had a big -- it was considered clinically appropriate for stuff to shift out of the hospital and into the outpatient department, so there was a surge in outpatient volume? Then if you have a separate system, that clearly reduces the unit payment a lot in the outpatient department. That seems to me worse than decreasing everybody proportionally, if you have a big increase in --

MR. MacBAIN: Let's use Jack's earlier example. Suppose there were an effective treatment for Alzheimer's that required fairly intensive treatment in an outpatient setting and resulted in a large shift of patient care from hospitals and nursing homes to the outpatient setting.

DR. WILENSKY: That's why you want a broad --

MR. MacBAIN: We penalize the very system that we're relying on to provide that care.

DR. WILENSKY: That's what he's saying.

MR. MacBAIN: So what we're really saying is, as long as Medicare overall -- if Medicare spending per capita is growing in a manner that consistent with the economy, we don't care who's spending it.

DR. NEWHOUSE: Be clear though. What we have now is a system where it's Medicare ambulatory spending is growing. That was Bill's issue.

MR. MacBAIN: And that may or may not be appropriate.

DR. NEWHOUSE: We need to come to that issue, but it can't be in the context of this letter.

DR. LAVE: I think we have to be careful. I think everybody sort of has a sense that it's going up a little bit too fast, but we certainly probably be it should have gone up a lot faster in the last 10 years than it went up in the 10 years before that because of the change in technology that has taken place, right?

DR. NEWHOUSE: Yes, but that's my problem in --

DR. LAVE: Right. So I think that we're all agreeing with you that we would rather go to an overall cap.

DR. WILENSKY: Or at least a broader cap.

DR. NEWHOUSE: But then I was asking why it's administratively difficult, because the letter says it's administratively difficult to have a broad cap.

MR. GUTERMAN: I have a question from the staff. You're talking about an overall Medicare program cap?

DR. NEWHOUSE: Not for this letter. That's an issue for a later date.

MR. GUTERMAN: What are you talking about for this letter?

DR. WILENSKY: For this letter I think what we're -- the concern about having the cap too narrow and that a broader --

DR. NEWHOUSE: We're talking about ambulatory cap.

DR. WILENSKY: A broader ambulatory cap would not be administratively difficult as long as it was specified what happens when you exceed the cap.

DR. MATHEWS: So you would bring in payment in the physician office setting?

DR. WILENSKY: Yes. Our recommendation would be to have a broader ambulatory cap rather than a specific ambulatory cap by site of care.

DR. CURRERI: But in the long run you really want to get away from that to a total Medicare cap so you can account for the shift from inpatient to outpatient.

DR. WILENSKY: Probably, but we don't have to make that decision today with regard to this letter.

DR. KEMPER: I agree with what you're saying I think, but what I was asking Jim was, what is the resistance at HCFA to that broader cap? What is the technical --

DR. MATHEWS: I'm not sure. I can look into that.

DR. NEWHOUSE: The letter says it would be administratively difficult to implement.

DR. WILENSKY: That's our letter.

DR. ROWE: That's our letter.

DR. NEWHOUSE: Our draft letter.

DR. WILENSKY: He's saying what's HCFA's resistance? That's what he was asking.

DR. ROWE: This is our -- we think it's administratively difficult.

DR. NEWHOUSE: Why do we think that?

DR. ROWE: He's asking HCFA thinks it's --

DR. NEWHOUSE: I assume that -- all right.

MR. MacBAIN: I still have a concern, if the main trend is from inpatient to outpatient, then if we lump hospital outpatient together with physician sustainable growth rate and ambulatory surgical centers we're still going to see that go up, potentially, faster than the SGR would allow because of a shift from inpatient to outpatient. We're just spreading the pain across a wider audience, so now physicians get to share in some of it. But it still isn't -- it's still reducing payments because the right thing may have happened, and I'm concerned about that.

DR. WILENSKY: We have, and we can again say, that we think the SGR that was set was too low. And to the extent we think the ambulatory SGR is too low, we can say that. But I think the point here is do we -- I mean, we can say no SGR, but I don't think -- that was against where we were.

We can say an SGR or an expenditure cap that is specifically for hospital outpatient, and one, which already exists, which is specifically for physician fees. Or we can see that it would be an improvement to look at the ambulatory as a group and say that whatever sustainable growth rate is applied, ought to be applied to the ambulatory and not just to each component.

My sense is that is where we are now, that most people think it would be better to have an SGR applied to ambulatory rather than to each piece of the ambulatory. We can say here and we can say in

another more appropriate place that we're concerned that having an SGR on ambulatory which is unrelated to an SGR -- maybe not the same, but at some kind of a growth rate for inpatient and post-acute is unwise.

MR. MacBAIN: For the system expenditures as a whole, because we also -- if it's still just on the fee-for-service side, you've got this other issue of how do you deal with movement into or out of Medicare+Choice plans. But I think what you're saying is let's -- if it's just going to be ambulatory for now because that's all we can practically expect, set the SGR high enough that we're not going to bump into it.

DR. WILENSKY: That's a whole different issue of what we set it at. What we're saying is that we ought to think about an SGR that includes other pieces of ambulatory besides just outpatient.

DR. NEWHOUSE: I'm assuming that SGR for Medicare as a whole requires statutory change, so it's outside the context of this reg.

DR. WILENSKY: Right. So we're just making a comment about the SGR for hospital outpatient. Are people comfortable with -- Peter, you're looking very --

DR. KEMPER: No, I'm just -- it strikes me I'm not sure we really have fully thought this through with this comment about we're setting up a cap that discourages the very kind of substitution of outpatient for inpatient care that we --

DR. WILENSKY: What our recommendation last spring -- I'm not sure that is what we're doing. Our recommendation last spring said that we ought to have a loosely-defined expenditure cap for outpatient. Have something in place but have it loose, because we thought there were still lots of movements going on.

The point we're trying to make now is -- but we don't have to make this point -- is that it makes more sense to think about ambulatory care as a group expenditure rather than as sector specific in

thinking about expenditure cap or sustainable growth rates. So that we ought to think about these various pieces of ASCs and outpatient and physician offices as a sector and not try to have different SGRs within them.

We can say here, but obviously it doesn't have any effect because it's outside of the current statute, that it would make more sense to have sustainable growth rates looking at broader yet pieces of Medicare.

MR. MacBAIN: I think we should say it, if for no other reason than to point out that when this first year is done and a bad result results, if it does, to sort of point out some of the areas that may have caused that that may not really be problems. It's better to have a larger definition of ambulatory, but it still doesn't deal with the fundamental difficulty of a sector-specific SGR.

DR. WILENSKY: Right. And I think there's a lot of sympathy --

MR. MacBAIN: Ted, what's your sense of this from a physician's perspective? Because we're lumping you in with the rest of the --

DR. LEWERS: I really don't know what the effect would be. I have no idea. It may be beneficial for the physician. I mean, I just don't know.

DR. WILENSKY: It's hard to imagine it's going to hurt the physician more than keeping it at GDP.

DR. LEWERS: That's true.

DR. ROSS: If I may, again when you're lumping all these together are you talking exclusively about the practice expense and the facility payment as being lumped together under one SGR, or are you including the work values that we currently have?

DR. NEWHOUSE: I was proposing one SGR for all ambulatory.

DR. ROSS: Irrespective of whether it's facility or physician work component?

DR. NEWHOUSE: That wasn't very explicit, I agree with you. So if people want -- we ought to see if anybody favors a narrower -- in effect, two pots.

DR. WILENSKY: Given the discussion we've been talking about, the broader -- the point we're trying to allow for shifts to occur that are either technically or medically or economically appropriate and try to get away from this silo mentality.

DR. NEWHOUSE: Yes, not have the payment system get in the way of what would otherwise be clinically appropriate.

DR. WILENSKY: George, do you want to add to this?

MR. GREENBERG: Let me just share a thought or two here. Again, we've wrestled with this, and of course, the reg says, we wrestled with it and we don't have a choice yet. But again, there are important trade-offs to think about.

It seems to me one option, when you talk about a broader SGR, is expanding the current physician payment system, which already has clinical lab services in the outpatient department in it. So one thought is, what else in the outpatient department do you think is really under the -- and again, the fundamental issue here is, do you think -- what controls outpatient volume? Is it the physicians ordering or does the hospital itself influence the physicians' behavior?

So I think that's the fundamental thing you need -- if you're going to have a separate SGR for outpatient, you've got to have some theory that the hospital can influence the volume or at least influence the behavior of the physicians. So I think those are important things to think about.

The other problem is whichever way you go there's a dilemma and there's a trade-off. If you have a separate SGR for outpatient, then -- again, where there are fee schedules, there are going to be differential updates. You've all dealt with differential updates for classes of services in the fee schedule, and at

least we went back to a single conversion factor. A separate cap at least opens up a non-level playing field where there are payments because you're going to have different updates based on volume in different settings.

If you go the other way, then you pull the hospital outpatient department apart. If you have the broad system, then there are going to be differential updates within the outpatient department for different services. That I think is an inevitable effect of going to one choice or the other. So I guess that's just an important trade-off to think about.

DR. NEWHOUSE: Why are there different updates within the OPD?

MR. GREENBERG: Because the physicians will be getting -- I think it depends on the different services that -- let me think it through.

DR. WILENSKY: It seems right now for purposes, again, of what we are advising HCFA we think -- I guess we can give a little more thought on this issue -- that it is our preference to have a broader ambulatory rather than a narrow site-specific SGR so that we allow for trade-offs to occur when they're clinically and economically appropriate. But the specific implementation about what you do if you exceed these ceilings is something that will require some further thought.

I'll ask for whether there are any comments from the public and then we will go into recess until 1:15. We're going to reconvene though at the scheduled time.

MS. WILLIAMS: Deborah Williams, American Hospital Association. I would have to say that we believe that patient care characteristics are very important to study. I wish I had more confidence analytically that we would be able to do so.

For instance, in the outpatient, the coding rules are that you code the reason for the visit, not the resulting finding like you do in the inpatient. So for example, someone comes in and they say they have

angina, and they have gas, the code will be angina. And the same way, if that person is a diabetic, it may not be recorded on the claim itself.

If you remember Chris Hogan, when he was looking at risk adjustment issues, found all these paraplegics that were miraculously cured the next year. So I think that you may even need some kind of multi-year bill to pick up what the underlying differentials really are.

The second comment I wanted to make was on the issue of accounting costs. The Medicare cost report is not for the faint-hearted.

[Laughter.]

MS. WILLIAMS: For instance, one of the things I've been thinking about is to calculate Medicare allowed capital costs you have to subtract off investment income. And I believe the investment income is not pro rated for Medicare's share. Medicare writes the rules, so they write it in a way that favors them.

So I began to wonder, for instance, what we observe as capital costs improving in the mid '90s, is that a lessening of Medicare allowed capital costs? Is that cost control, or is that merely the financial market doing better and trends in bond crossovers? I don't really have an answer for that.

And the same way, I'd like to say another issue obviously that's not for the faint-hearted is, of course, the site of service differential. We know that there are different regulatory requirements as well as you've got to think about the payment. For instance, what's the effect of differing labor shares for ASCs versus the hospital OPD? If you had payments that were similar or very closely the same -- for example, diagnostic colonoscopy is higher in ASCs today than hospital OPDs. Do you, because of the differing labor shares, give an incentive to establish ASCs in rural areas in a way that's detrimental, pulls off the easier patients from hospital OPDs?

There's all the ways these little adjustments to the payment system sort of work out that might spill over. And I know this is what you're getting at. I just wanted to point out that it's just, again, another way perhaps that's not for the faint-hearted.

MR. LOPEZ: Jorge Lopez with Akin, Gump, Strauss, Hauer & Feld. I'm here today to comment briefly on outpatient PPS on behalf of the 10 freestanding National Cancer Institute designated cancer centers.

As you might have seen in the presentation, OPPS is going to have a very, very significant financial impact on the cancer centers. By HCFA's own estimate, the expected reduction in Medicare outpatient payments is in excess of 29 percent, which is almost eight times the national average impact of 3.8 percent. And we have done some internal calculations of our own that show that that might be conservative. Our internal projections are that the possible impact may exceed one-third.

So obviously, the cancer centers are very concerned about this, and we worry that losses of this magnitude might have a very significant impact on the ability of the cancer centers to fulfill our mission of providing state-of-the-art cancer treatments for the Medicare population.

The reason that we think that we're adversely impacted in this way dovetails with the reason that the cancer centers were originally exempted from inpatient PPS. That is to say that we believe that our practice of medicine is simply incompatible with a prospective payment system that does not recognize the unique characteristics of our patients and the intensity of the services that we provide. That really is what is comes down to.

In that regard, one very important factor is that because of the very narrow focus of the cancer centers, we cannot avail ourselves of averaging. In other words, when we provide money-losing services, such as state-of-the-art advanced cancer care, we can't offset that with more favorable payments for

other less complex treatments. That's a very important fact and something that I think is integral to understand why the cancer centers lose money under this proposed system.

What we have proposed to HCFA or are in the process of proposing is some kind of payment adjustment for the cancer centers that would recognize our unique circumstances. As you may know, in the Balanced Budget Act, Congress asked HCFA to consider establishing a separate conversion factor for the cancer centers that accounted for special characteristics. We're currently preparing comments to the agency that will make that request and ask them to establish such a conversion factor.

Thank you for your time.

DR. WILENSKY: Thank you.

MS. McELRATH: I'm Sharon McElrath with the AMA. On the basic question that George raised as to whether you want to do more bundling or whether you want to extend a fee-for-service approach across the whole waterfront. I think you need to keep in mind that when you bundle in physicians' offices you end up with a system -- I mean, people are worried about whether there's too much averaging in this system even for the outpatient departments. When you move this into a physician's office and you have some physicians who tend to get all the most complex cases, then your bundling problem becomes even worse. So I think that you need to think about that.

In terms of how would we like for the SGR to work. For starters, we would like for it not to happen at all. But the question of whether you should lump it or not, I think that it would be good to have some simulations of what would happen and how would you -- once you had lumped these things together, then when you were trying to apply the adjustments, how would you do that? Would you do that on each part of this system, have a different one, or would everyone have the same?

If hospital outpatient is growing -- I'm not sure of the number but I think it's in the range of 12 percent. Physician expenditures are growing in the range of 3 percent. That's a big enough -- and hospital outpatient is going to be a big enough part of the whole part to really shift the numbers around.

We have physicians already looking at a negative. You always talk about, we would have a more generous cap. Frankly, we've heard that before. We started out with a more generous cap and then we are down to one now where we are looking at negative SGR.

Then just finally, I think that physicians already have an incentive to -- because under their own SGR a lot of these services that are being done in the outpatient department are services that -- they are penalized already if they perform too many surgeries or if the expenditures go up for surgeries. So the degree to which you get more of an incentive for physicians to practice efficiently, it's not a 100 percent kind of thing.

DR. NEWHOUSE: Can I pursue that a minute, Sharon? Let's take your example of the 22 percent versus the 3 percent.

MS. McELRATH: Twelve.

DR. NEWHOUSE: Twelve percent. It seems -- one response, I suppose is that the 22 percent was mostly an accounting artifact and it's fine, therefore, to whack the outpatient rate 22 percent.

But it seems to me if you've got -- this goes to George's point really, I suppose, about differential updates. Once you've got the two systems, if you're trying to maintain some kind of system that has relatively neutral prices between the outpatient department and the office, that if you then superimpose on that shifts that are real in terms of where the thing is being performed, that you then unbalance your prices, just because of the differential updates. Is that right?

MS. McELRATH: We haven't come down on one side or the other. I just think it would be good to good to have more information and to think about it in more detail as to how it would play out before you went one direction or the other. I think that the PPRC report -- I don't remember which year, but the year when we were all talking about lookbacks -- that that would be instructive because it went into some of these same kinds of questions.

DR. WILENSKY: I agree. I think that we are talking about something that's significantly different from where we are now. It would be instructive to do some simulations to try to get a sense about what would happen if we put in place such a system, and to look at the results.

In part, actually I think some of the concerns and considerations that came up after the '95 proposals when you were having nine separate lookbacks is what we're concerned about and that's why we are looking toward a broader cap rather than a sector specific. But I think it's easier for us to say what our principle is, but I think it's appropriate to say exactly how you would implement this and the implications it would have, is something that we ought to at least try to do some simulations.

MR. MacBAIN: For purposes of writing a letter to the HCFA administrator though, where are we? I'm kind of lost.

DR. WILENSKY: I think as I have heard it, unless people want to change their mind before it actually goes in, we are advocating a broader rather than a narrow SGR in terms of ambulatory care. We think that it's preferable, and the issue of exactly how it gets allocated out is something that we can raise. But that is what I have heard people -- and again, I think, on balance, it's preferable to having this narrow silo SGR.

MR. ASHBY: I know this is public comment time, but I thought it might actually be useful to go back and review some of the findings that we ourselves did come up with on these accounting cost issues a number of years ago.

As George Greenberg alluded to, we did do a major study about five years ago where we attempted to get at real resource costs, and we did so by going to a number of hospitals that had implemented the most sophisticated cost accounting systems that the market had, to generate information for themselves on their costs by payer and between inpatient and outpatient. We then, for the same set of hospitals, compared to what is generated through the Medicare cost report to try and get a handle on how accurate the Medicare cost report data is.

We did, on the one hand, as George mentioned, did find the expected. That is for ancillary costs, particularly to ancillary costs there is indeed a rather major shift from inpatient to outpatient, or an overstatement of outpatient cost. The numbers were on order of about a 20 percent overstatement of outpatient ancillary costs and about a 4 or 5 percent understatement on the inpatient side.

But a couple of other things were of interest. One is that on the allocation of overhead, we actually found very little evidence of allocating overhead costs differently between inpatient and outpatient except that we were cautioned by the experts that one of the leading techniques for doing this is virtually undetectable, and that is what they call direct costing. You take your housekeeper or your billing clerk or whatever, and you take them out of their respective department and you employ them in the outpatient department where 100 percent of the cost will now show up there.

The trouble is, we could not measure that. And if we redid a study today we still basically would not be able to measure that.

One other thing that's kind of an aside but is really sort of interesting to just keep in the back of our minds, and that is that while we found some evidence of Medicare outpatient costs being overstated, we also found evidence of Medicare inpatient cost being overstated on the Medicare cost report.

That takes place not on the ancillary side but on the routine cost side where the evidence of a hospital's own sophisticated cost accounting system showed that Medicare patients on average are less costly to treat on the actual nursing units than are other patients. So the misallocation is between Medicare and other payers rather than inpatient and outpatient. On balance, we found that Medicare inpatient costs were about 4 percent overstated in the cost report relative to our best estimate of what they really are.

DR. MYERS: I'll reask Joe my question from 30 minutes ago. Given that report, it's clear that a study is possible. We've done it before. Five years have passed. Don't you think it would be a good idea to redo it and even in a more sophisticated way at this point to really get a baseline as to where that shift has actually changed?

DR. NEWHOUSE: We should see what everybody else thinks. I guess my answer depends on (a) the cost of the study; (b) the answer to Jack's question about the stealth janitor who got allocated over to the outpatient department. I mean, the study may not be all that helpful.

DR. MATHEWS: The study that Jack's referring to was a study using 1988 cost reports for I believe 78 hospitals. I don't know how representative they would be currently or to the 5,600 or 5,700 hospitals that might --

DR. MYERS: Why is fresh knowledge not useful? I don't get it.

DR. WILENSKY: To the extent that you think that there really is an allocation and it's happened by making indirect into direct costs, you're not going to see it. That's the only thing, is that if you really think that that's where the big action is going on, that you have arbitrarily labeled direct what is really indirect --

DR. MYERS: And there are not other ways for us to get at that?

DR. WILENSKY: Apparently not. But we can think about that some more and get back to you. That's really the issue, is if that's where the action is and you're going to miss it -- you missed it before and you'll miss it again -- you're not going to really answer it.

I know we have gone substantially over. Let me plead with commissioners to try to be back here at 1:15. We have two more sessions before we finish this afternoon.

[Whereupon, at 12:46 p.m., the meeting was recessed, to reconvene at 1:25 p.m., this same day.]

AFTERNOON SESSION [1:25 p.m.]

DR. WILENSKY: We have a major section on access to care; Nancy, Susan, and Janet. Nancy, are you leading off?

MS. RAY: Yes. Good afternoon. I'm Nancy Ray and I'm going to be presenting, along with my colleagues Susan Philip and Janet Goldberg, access to care and our proposed workplan.

In putting together your reading materials and the proposed workplan we first reviewed previous Commission meeting transcripts and reports as well as reviewed some of the more recent peer-reviewed literature. Our workplan represents a broad view of access that has previously been taken by the Commission. We considered access to be "the ability of attaining timely and appropriate health care of adequate quality such that health outcomes are maximized." Using this broad perspective, access to care affects beneficiaries' use of services and ultimately their health outcome and quality of life.

Previous Commission analyses have examined various access issues including how characteristics and organization of the health care system affects access, differences in access based on

beneficiaries' socioeconomic status, and how access affects beneficiaries' use of and satisfaction with health care. Our workplan builds upon this previous work.

In your reading material we reviewed the conceptual model that has been used in the past to study access. What I would like to focus on this afternoon are the six proposed projects that we set forth in your mailing materials that will continue the Commission's work in access.

As I said, the six studies build upon previous work by the Commission. Additionally, the common theme is to try to flesh out reasons why certain groups of beneficiaries are vulnerable groups, have limited access compared to non-vulnerable groups. We want to try to get a better handle on what are the barriers of care, which will hopefully lead us into figuring out what strategies and programs can be implemented to reduce access inequities.

As numbered in your workplan, the first three studies are what I call qualitative. This is using the same numbering scheme in your mailing materials. The first is a literature review. The second is the early warning system. The third is focus groups. Then the last three studies are three formal data analyses using administrative claims data and survey data.

Not to confuse you but I'm going to be presenting the studies in slightly different order. Actually, I think we'll be saving the best for last. I will first be presenting the literature review and the three formal data analyses, Janet will present the focus group project, and Susan will present the early warning system project.

The review of the literature really speaks for itself. We want to look at peer review literature published during the last five years. We want to obtain copies of reports published by nonprofit foundations to look at what other people have studied in access and what their findings are. We want to specifically target studies that have to do with vulnerable populations, with diffusion of technologies among Medicare

beneficiaries, use of health care services, how beneficiary attitudes affect access, and different kinds of interventions that have been used to increase access among all patients.

Going on then, if there are no questions up to this point, to the next study is the first of our three formal data analyses. In reviewing the literature, various researchers have concluded that increasing access to care, especially among vulnerable groups, must be based on changing their perceptions and behavior as well as modifying the characteristics and organization of the health care system.

This study tries to better understand the relationship, the interrelationship between beneficiaries' attitudes and realized access to care. The objective of this study is to look into the interrelationship between beneficiaries' attitudes, subjective access indicators, and actual use of services, objective access indicators, for different vulnerable groups.

The goal of the study is to try to better understand disparities among groups of beneficiaries that have historically had limited access to care with the ultimate goal of trying to make some possible recommendations to HCFA for additional interventions and programs among these groups of patients.

The data source for this study will be the Medicare current beneficiary survey. This survey includes beneficiaries' opinions about how satisfied they are with the quality and availability of medical care, their confidence with their medical provider, and whether they think their provider has a good understanding of their medical history, as well as whether they seek medical care when they're feeling ill.

The objective access indicators, we are looking at three different kinds. The first will be use of preventive services, and that's obtained from beneficiaries' self-reports that's included in the Medicare current beneficiary survey.

The second measure will be hospitalization for ambulatory care sensitive conditions. These are conditions that have been previously defined by the Institute of Medicine and the Agency for Health Care

Policy and Research. These are conditions that are considered to be treatable in ambulatory care setting and consequently should not result in hospitalization. This measure is increasingly being used as a way of looking at access among different groups of patients. Examples of these conditions -- and they were included in your workplan -- are diabetes, asthma, COPD, and pneumonia.

The third objective access measure will be to look at overall use of ambulatory physician services, emergency room services, and inpatient hospital services. Both this measure as well as the ambulatory care sensitive measure would be determined using claims data.

Going on to the second formal data analysis --

MR. SHEA: In that first study, do you know if that survey includes questions about whether, instances of where people needed care or care was recommended by a physician but wasn't, they weren't able to get it? They didn't get -- including pharmaceuticals.

MS. RAY: There is a question in the MCBS that I believe says that they did not get a pharmaceutical due to cost, yes, and we can take a look at that.

DR. WILENSKY: Is there also information on whether a physician visit was recommended? I think on NAMSI's --

MS. RAY: On NAMSI's there is, yes.

DR. WILENSKY: Is there anything on the CBS that would give an indication that something was recommended and whether or not it was used?

MS. RAY: I will look into that.

DR. KEMPER: Do you want comments on each one as you go along or do you want to finish?

MS. RAY: I'm okay either way, whichever you prefer.

DR. WILENSKY: I think I would just as soon -- although we run the risk that we had this morning and you'll have to give us some guidance if our comments start becoming so involved with a later presentation, just tell us and then we'll have the later presentation.

I'd like to raise an issue that is a very broad-based issue and just get some reaction from other commissioners about whether -- if they agree, and if so, how else to handle it. This is the question about whether or not we include use as access. I like very much the empirical work that is being implied in terms of looking at whether preventable diseases occur, or use of services or not use of services that may have been recommended by physicians.

I think those are very important measures for where we are in the health care system. But I have trouble with regarding that as access. We can call terms what we want them sometimes, but I tend to regard access as a general physical availability within some kind of time or geographic constraints to meet health care -- more the first, the narrower definition. And just have difficulty calling use access, because use has so much combined with the individual's own actions and views toward the health care system, and efficacy, and potentially economic areas.

But I find that there's -- I mean, I would like to know something about whether there's a problem with physical or geographic availability. And I think it's very instructive to know if people don't use recommended services why they don't use recommended services. It might be that it's physically there but it's not there at a time of day when they can get to it, and I would regard that as an access measure. So it's not just geographically there but something about it, at a time when you can reasonably get there.

I just personally find it more confusing to lump in the use and occurrence of preventable disease. Again I want to be very clear. I want to have that analysis because I think it's a very important analysis. I just feel uncomfortable not distinguishing these kinds of measures, and calling one much more --

access is access, and something else a lack of appropriate use, or recommended use, or however we want to term it. But I just have trouble putting these two concepts together.

I don't know how other people react to that, so to help me -- again, I want to be clear. I don't want to not have this in there. I think it's very important information. I just would like it really distinguished, and use almost anything other than access.

DR. MYERS: Are you looking for comments?

DR. WILENSKY: You're welcome to make your own comments. I wanted to raise this now because it goes to the heart of how we're thinking about this now. Again, it would not take a whole lot to make me happy in terms of the distinction, but rather than raise it each time we get to it, to have this discussion earlier. So you can either comment on that, or if there are people who want to comment on that and then also comment on what we've had presented.

DR. MYERS: I think it's even more complicated than that, and I was going to make this comment when we were having our discussion of physician supply. If you drew a diagram, there's overlap between supply, access, and use. But there's clearly an area in all of them that doesn't overlap.

When I was commissioner of health in New York I would always wonder why there was an access problem in that most of the facilities were within one or two subway stops of where the patients were. That's when I was really hit very hard with the notion of being welcomed, the notion of whether or not you were being encouraged to come versus discouraged to come.

And especially with the frail elderly, especially with the elderly patient that doesn't necessarily fit the socioeconomic desired patient characteristics that a particular group of physicians or a clinic would have. That is a real issue. Whereas you and I may not be discouraged by that, many of them very clearly

and definitely are, and can be easily discouraged by the way that they're treated, the staff questions that are asked.

How do you factor that into the notion of the GeoAccess program where it's clear that within a very limited space and they can get there relatively easily, yet they clearly will not use the facility. And that's good according to some of the people that want to discourage them from being there. So I would just add that as even an additional complicating factor when thinking about access, use, and supply.

DR. KEMPER: I think that would be an appropriate topic for the focus groups to -- that's not going to show up in the data but it might well show up in the focus groups.

I guess just responding to your comment, Gail. To me, it's sort of a semantic matter, and if there's a semantic solution, that's fine to call it access, use and satisfaction. There are also I think some sort of satisfaction or assessment indicators here which I wouldn't -- might not call it just access. Some people would clearly say access is the whole ball of wax and some people are just, can you get to --

DR. WILENSKY: Let me -- I mean, I think you have to be careful because access can suggest -- and I'm going to give you an example -- can suggest some appropriate or reasonable policy responses and these can be very different things. We've talked in this country about our low rates of vaccination and immunization. And depending on whether or not you had -- cost of the vaccine might be an issue for some people. Whether or not you had facilities that were available.

When you hear reports of mobile vans going into public housing units and 60 percent vaccination rates of two-year-olds, it's not -- I don't want to make this that this is not a serious issue. But when you say access, you get people coming up, in my mind, with funny policy responses because you're not -- I mean, I think access to most people does mean something about reasonably, conveniently available in

geography or space. And I think people also would -- they might put it on a different level but say, that even if it's there, if you're really shunned in some serious way, it's there but it's not there.

But I think that how we use these terms of do we "have an access problem in Medicare" and what is it, or if we have a change in payment rates and we see some utilization differences, or if we have a change in arrangements do we see some utilization differences, I'm just uneasy about lumping that under, we have an access issue here. So I regard it -- obviously any time you put a label on it at some level it's a semantic problem. But I regard it as more serious than just, it's a semantic kind of problem in a sense that you can call it purple --

DR. KEMPER: I guess there are two issues in my mind that go beyond the semantic. One is, what do we look at? What kind of data do we present? And I think there's both access narrowly defined as you're using the term, and utilization, and some measures of satisfaction are all useful to look at. What inferences you draw about it could be quite different because I don't know whether more service use is better or worse. It sort of depends what it is and so on.

But if you see that all of these measures are lower for one group than other groups, I think that raises a red flag and access of that group, even if no one of those indicators would lead you to say there's a problem. When you look at the whole set of them then you start to raise questions about whether there is a problem with the Medicare delivery of services to that group, whether it's access or other kinds of problems.

So I would just argue that we ought to look at all of these measures and then be cautious about what kinds of inferences that we draw from them.

DR. WILENSKY: I guess to the extent that we can clearly distinguish them, we have frequently used in the past, there's access problem, let's increase the reimbursement rates to such and such so

we'll have more of them. But in fact, if they're there and they're not being used, it's not clear that that's a particularly appropriate policy response. There's something else that's going on.

So as I said, this is an issue I have had to wrestle with for the last 25 years since working with Ron Anderson and friends on this issue. Part of is, economists meet medical sociologists and we stumble over some of the concepts.

DR. KEMPER: Can I just make one other comment? One thing on this analysis, I wanted to make sure that you had in mind doing the time trend analysis and talking about how these measures, both the subjective and the objective measures have changed over time, and continuing to do that kind of monitoring of access. Because it seems to me that would be very useful.

So it wasn't explicit here, but that to me would be -- whether it's the clinically based indicators or the current beneficiary survey measures, those time trends seem to me, from my perspective, the most important thing to do.

You stated the goals for this analysis comparing the subjective and objective measures, which I fully agreed with and it's very well stated. I didn't quite understand how relating the subjective to the objective measures would meet that goal. As I understood it, the goal was to try to identify where there might be problems with people getting services for whatever reason, and then try to figure out what the reasons for that was.

I mean, you had a much better statement of it than I did about what the objective was. I didn't see the relationship between the objective and the analysis, how that would inform that. So maybe you could say a little bit more about that.

MS. RAY: What we wanted to try to flesh out in the analysis is, for example, in looking at patients who say that they're very satisfied with the care that they're being delivered, what is their actual use?

Let me backtrack a second. Of people who are very satisfied with the health care system, what is the rate of preventable hospitalization and does that differ compared to people who are not satisfied? And to see if that goes in the direction that you would expect it to within given beneficiary socioeconomic groups. Or if it differs based on the "vulnerable group" that you're put into.

DR. KEMPER: But it just seemed to me there's a simpler, prior question is looking at all of these various measures, how do they vary across groups, and why do they vary across groups? That the interrelationships among the various measures, I couldn't see immediately how that would help understand where there might be a problem and what the nature of the problem might be. Maybe you can just think about that.

MR. MacBAIN: I think we got into all this in the context of what we're going to talk about a bit later, the early warning system, and were these changes that are coming down, particularly the physician payment fee schedules going to produce access problems where there hadn't been any before, or were specialists going to stop participating and so on? In that context I think we are talking about a change in use as being the measurable variable that would be an indicator.

So if we're going to do a broader survey of the differences between availability of services and actually use of services, that's fine. But I don't want to lose sight of what got us into this initially, which is a change in patterns of use occasioned by changes in the payment policies.

MR. SHEA: There's a lot of history behind this access debate and I think my perspective historically differs a little bit from the one that you expressed because my concern over time has been that if you were too -- you could err on the side of missing some people who are having problems getting the services they need. But I don't have any problem with looking at this in a different way, or breaking it out into different categories.

The one thing that I think is important that we try to capture is, if there are significant obstacles to appropriate clinical care, I think we want to know in all the different ways that that occurs.

DR. WILENSKY: I agree. It's just I'm more comfortable talking about it in those terms.

MR. SHEA: The one that's in the front of my mind is this drug cost question, because we've heard so much about that and I know it's getting a lot of attention in the Commission.

DR. WILENSKY: But actually I think that that's a more comfortable phrase of art for me than calling it access.

DR. LAVE: I want to ask one question about access. I agree with you about what it is that we really want to distinguish between things which I think are sort of access issues which sort of are indicators of the types of barriers that people may face in seeking care. That may be one way to define it as an access issue. So the doctors aren't there; the doctors won't treat them; the doctors snarl at them.

The one issue that I think we should raise up front -- I was just following Woody's comment. He's a physician. He raised it. I never knew any doctor that was like that.

But the question that I have in terms of this is whether or not we ought to be tracing, in terms of access, the financial constraints, in terms of the proportion of people who have Medicare only as being an access issue and other issues. So that in fact we can actually try to zero in on the cost as being a specific access barrier.

For instance, I was looking at this data on delay due to cost of care and I would have found this extraordinarily informative if I had had the insurance status across there. Because then I would know whether or not in fact this was primarily a cost -- I mean, you could tell pretty quickly whether what you're observing is primarily a financial access issue or whether it is a whole host of other things, and to what extent are they divided up in that way.

I think that to the extent that we can do that, that it would be helpful to try to find out of these phenomenon that we are concerned with. And I think that we want to focus not on sort of use, but on use of people say that matters to them. So that would be something that I think I would put up front, because if that turns out to be the big issue then we have a, you know...

MS. NEWPORT: I guess I want to agree with everybody. Reading this I was trying to, I think as Gail has rightfully identified, define what we're looking at, what we need to look at. It comes down to, there's just a lot of issues on the table.

But just going back to the what the lead-in on our materials says is -- the thing that resonated with me is vulnerable populations. What are they and how do they get care? Access and availability is a term that is used commonly in my industry and I think that we're trying to capture a lot of ephemeral things here but not necessarily things that are unimportant.

So I guess I'm just trying to say, we need to define this very well for ourselves so we do understand what this is. Maybe perhaps in this day and age we need to revisit the issue of our payment system's changes impacting this, and maybe not.

There may be a lot of things that we identify as a problem here, but I'm not comfortable in saying right now exactly what it is except that I have this need for some kind of definition. What are we looking at? Is it access? Is it availability? Is it the vulnerable populations? And where do we start? Do we start with the most vulnerable and identify who they are and then work our way into the rest of this?

I have more questions than answers, obviously. But I think we need to define this very clearly before we -- or understand. Let's not define it. Let's understand where we need to go on this. All of this seems like very good work and very positive directions to go in, I'm just not sure where we're -- it's so broad. I'm seeking a finer definition.

DR. LEWERS: I agree with definition. I agree with essentially Gerry's definition as I understood it. But also in definitions, Nancy, you've used two terms which I'm trying to figure out where that's coming from.

You've used the term of providers and surveying providers and the satisfaction with providers. Then in another spot you've used physician. Are you looking at using the term physician as provider, or are you looking as all other elements as far as providers, hospitals, et cetera? I just wasn't clear. At one point you used that term provider and then at another point you talk about ambulatory physician services, which is a broad spectrum. So can you clarify for me exactly what you're surveying?

MS. RAY: Sure. For example, when a beneficiary is asked where his or her usual source of care is, that may indeed be a physician or it might be some other type of medical provider. I apologize for perhaps using the term interchangeably, and it's not. I think it matters specifically to the context that I've used it.

MS. JACKSON: For those of you who know that I have frequently said that there seems to be an access problem with a certain category of beneficiaries and it never came -- I seem to have gotten it from what someone said but not from a study. You would say that the study says that there is no problem. We, meaning Medicare beneficiaries, say that there is a problem.

I would think that if this is going to give us any information that says that there's a real problem, then we should do it. And we should also be able to determine, what can we do about it?

DR. NEWHOUSE: I just have three small suggestions for you. The first is, you've given us a lot of one-way classifications. I'd prefer to see multivariate analysis, even when we go to Judy's comment that she wants to see it with Medigap, no Medigap. I would rather have that than controlled.

Second suggestion is, when you want to compare the Medicare eligibles with the 55 to 64, you might also consider a category of the over 65 with employer-based insurance as a comparison group.

MS. RAY: We can do that.

DR. NEWHOUSE: Third suggestion goes to the satisfaction measures. There's a second generation of measures -- and I don't know what access to have to data that use them -- that basically go to patient report and they differ from satisfaction because they ask patients about specific experiences they had or didn't have.

For example, were you told about possible side effects of your medications? They're an improvement over satisfaction in part because satisfaction it's very variable, and particularly it's not very variable among the elderly who tend to report that they are satisfied, whereas this spreads people out more.

So if you can get at those kinds of measures, I would suggestion you do that.

DR. WILENSKY: Peter, and then I think we ought to go on to the next section.

DR. KEMPER: One comment on this, and that is that it seems to me the financial liability work ought to be coordinated with this work. It just seems like they're intrinsically related, at least along the dimensions that Judy mentioned. But also just focus on income and expenditures as a percent of income and so on.

DR. WILENSKY: Do you want to go on to the next section of this area?

MS. RAY: The second formal data analysis is to use a survey that's recently been made available by the Agency for Health Care Policy and Research. It's called MEPS, the Medical Expenditures Panel Survey.

What we want to do with this survey is twofold. The first is we want to look at what we're calling access here, between people enrolled in Medicare who are 65 to 74 years of age to people nearing

Medicare enrollment; that is, people 55 to 64. We think this is important because we would like to look at how Medicare changes, or if Medicare changes access among specific groups of patients. Even though this will be a cross-sectional analysis, we think that we can gain some information from this analysis.

The second goal of this study -- this survey includes information about whether or not the Medicare beneficiaries are enrolled in the fee-for-service program or in an HMO. So we want to look at differences in access of Medicare fee-for-service versus HMO, and to the extent that we can, compare these findings to what has previously been reported from the Medicare current beneficiary survey.

The first question is, what is MEPS? Again, MEPS has been conducted by AHCPR. It is a household survey and provides nationally representative estimates of health care use, expenditures, sources of payment, and insurance coverage data for calendar year 1996 for the U.S. civilian, non-institutionalized population. Unfortunately, not all of their files are released yet so we are working with the information that is currently available.

There's information with respect to patient satisfaction with care, and there's information regarding use of health care services with self-reported use of preventive services like cholesterol testing, going for a physical, flu shot, prostate exam, pap smear, breast exam, and mammogram. Then right now there is overall use of office-based physician services, outpatient department services, emergency room, inpatient hospital, and home health care services.

I'll go on to the last of the data studies that we are proposing. This one, the goal of this study is to update the clinically-based indicators that were previously developed by PPRC. We are proposing to use data from

mid-1997 to mid-1998 and compare these indicators to those derived previously by PPRC in two different analyses, '92

to '93 and mid-1994 to mid-1996.

We think that this is important because this will -- going back to a previous question, it will provide us with a historical assessment as to, if there is a difference in these clinically-based indicators, and then within which population groups does it occur.

This study will use a methodology similar to the one used by PPRC in 1995 and 1997. Just very briefly, a 1 percent sample of elderly Medicare beneficiaries will be selected for this analysis. This analysis uses Part A and Part B claims data. Specifically, individuals who were enrolled in Medicare Part B during this period of time and received their care in the traditional Medicare program will be potentially eligible for inclusion in the study population.

Like I said before, questions that we will be able to answer from this project will be, for example, has the use of recommended services changed in the last six years? Has it remained relatively stable? Are there changes among specific vulnerable groups?

Lastly, I've also proposed to construct the hospitalization ambulatory sensitive measure and add that to the clinically-based measures to start us looking -- using that measure for this claims-based analysis.

DR. KEMPER: I think the clinically-based indicators are great, and the tracking of that should be high priority. On the analysis of the medical expenditure survey data, what will we learn from comparing the near elderly to the elderly? I understand there's an issue of extending Medicare coverage to the near elderly, and if that's the focus of it, I'm not sure whether we want to get into that. But if that's not the focus, then it seems to me there are a number of uninsured people in the near elderly group and we could find out that their access was lower and -- I'm just not sure what we would learn from that.

With respect to the comparison of HMOs to the traditional fee-for-service, I'm not sure why the beneficiary survey isn't better for that because it's got a much bigger sample. But if we do it with either one, you need to be careful about differences between the groups, and that's not a small qualification.

I guess my real question is, what would be the value added of those two analyses compared to the current beneficiary survey? And one answer might be -- I'll go back to Joe's comment earlier -- that there may be a lot more of these subjective -- that we may have gone to the next measure of self-report quality indicators of particular visits and so on. If that's the case, I would suggest you might just look at that relative to the vulnerable populations and compare those. It just strikes me as a big investment.

DR. LAVE: I want to talk about the clinically-based indicators and the concern that -- I have one concern and a question. The concerns that I have about it, particularly in terms of the time trend, are one that Peter alluded to. That is that between 1992 and 1993 and 1994
to 1996 we've had a large increase in the proportion of people who shifted from the fee-for-service sector into traditional Medicare. So you're not really comparing the same populations any more.

So I don't know what you can do about it, but it does strike me that you at least would have to age -- you'd have to age adjust it, at least, it would seem to me in order -- if you're going to look at this in terms of your trend lines. Because it may be that the people remaining in traditional Medicare, for instance, are older because they are less likely to shift than the younger people. So that's just sort of a caveat for doing that.

The second question that I have is a question of sort of interest. That is, do we ever recommend that women stop getting mammograms every two years? I mean, is there an age beyond which we should not be counting this measure any more? I can't imagine, for instance, in a million years persuading my mother to go and get a mammogram. I just don't know whether or not there is an age at which it's no longer recommended every two years. Because it would also make a difference in how you interpret this data.

DR. LEWERS: It is debated, but I don't think there's been any standard.

MS. ROSENBLATT: I want to generalize the question Judy just asked because when I was looking at the charts on page 14 to 15 in the material that did a time comparison, it was interesting to me that some of the measurement improved and some of it didn't improve. The question I asked myself as I was looking at the stuff that got worse over time was, is it because practice patterns have changed and there are people out there saying you really don't need to do that?

So I think if we could look at all of these measures and get some clinician to say, don't look at this one any more, it's not relevant any more, practice patterns have changed, that would be helpful.

I also want to add on to what Peter said about the comparison of the 55 to 64-year-olds with the 65 to 74-year-olds. I think looking at those two groups, there's just a lot of noise. I know you're sort of stuck with the data that's available, but it would seem to me that working status in the 55 to 64-year-old group in particular -- in the 65-plus also because of Medicare as secondary payer and all that kind of stuff -- that working status might be important if that is available in the data.

Because I think there could -- if there is in fact a problem that you read about in the press about the 55

to 64-year-olds losing coverage or in fear of losing coverage, that's going to add to the noise, and working status just might be important.

DR. NEWHOUSE: You've got that, right? You know that.

MS. RAY: Yes.

DR. NEWHOUSE: So it's not in the noise. You can do that for us.

MS. RAY: Yes.

MS. ROSENBLATT: So you're saying we can adjust for working status?

MS. RAY: Yes.

DR. NEWHOUSE: And insurance status in the under-65.

MS. RAY: Yes.

MS. ROSENBLATT: The other thing that might be important is to distinguish between where the insurance is coming from, whether it's privately purchased as an individual or provided by the employer. Because my guess is, at that age, if it's privately purchased it's much less insurance coverage, and that might be the only way you're going to pick up on that. Might have very high deductibles and it might limit the number of conditions, et cetera. So somebody has lost their employer-provided coverage, they may be forced to buy something that's very, very limited.

Finally, just another data source that you didn't hit when you were listing all the research things, and I don't know how good or bad it is. But there are a lot of states that provide benefits, states as employers and as ex-employers.

So if you look at like CalPERS, or you look at the state of Illinois, or the Massachusetts state program, these are programs that insure hundreds of thousands of people in some of these big states like Chicago, like Illinois or Massachusetts. They also often include coverage for after you retire. And a lot of that information could be made public, I think, if you got in touch with the right people and asked it. So just another idea about sources of information.

MS. NEWPORT: In this section I guess -- again going back to our need for definition, I was reading your slides saying compare access between beneficiaries enrolled in a Medicare HMO and beneficiaries enrolled under a traditional fee-for-service program. That's different than the kind of discussion we're having right now in terms of clinical indicators, depending on how you define access.

I am pointing it out, for example, access in some states for managed care entities is very strictly defined; so many specialties, so many -- depending on your projected population, drive times, things as mundane a that. So I think that it's important to again, sort of touch back how we're defining this.

The other part in terms of sources of data -- and I think Alice has got a good idea -- is in terms of the large employer groups that might have a large retiree population as well. But also looking at some of the -- although it's very formative, the Medicare HEDIS data that is starting to be reported. That may be two years out before you have an acceptable measurement in some of these areas. But that might be beneficial to take a look at in terms of what you're finding on the fee-for-service side. Just as an option.

MR. MacBAIN: Will the data let you do a comparison between access as measured by the clinically-based indicators and designation as medically underserved or health professional shortage area?

MS. RAY: Yes.

MR. MacBAIN: That might be interesting.

MS. RAY: Yes, and that actually was done in the past and we were planning on doing that.

Moving the presentation on then, Janet is going to now present our focus group concept.

MS. GOLDBERG: Questionnaire data provide an indication of where there are disparities in access to care and what populations are potentially vulnerable to access problems. However, we do not fully understand why disparities in access exist. We think that focus groups will provide useful information that will increase our understanding of the reasons for access problems among specific vulnerable groups of beneficiaries.

Focus groups will also help us understand how beneficiary and health system characteristics affect the use of services, beneficiary satisfaction, and health outcomes.

Information from focus groups will enable us to refine and improve future quantitative analyses. Therefore, we think that this method will provide valuable beneficial information. We anticipate that focus groups will generate hypotheses for more formal data analyses. They will also provide an opportunity to explore personal experiences and views which may not be captured by written questionnaires such as the MCBS, the National Health Interview Survey, or the MEPS.

Focus groups accomplish this by probing beneficiaries' beliefs, attitudes, and perceptions about various aspects of beneficiaries' interactions with the health care system. Information about personal experiences and perceptions will complement and enhance analyses of questionnaire and claims data.

In addition, focus groups may suggest areas where new survey questions may be needed. Finally, the group dynamics of this method stimulate discussion.

There are several drawbacks associated with focus groups. One drawback of using focus groups is that the findings will not be generalizable. There may also be circumstances that are out of our control that could affect our results.

For instance, some participants may be reticent about discussing their opinions, or one participant may try to dominate a discussion. Careful selection of a moderator who has extensive experience with facilitating focus groups will help increase the quality of the information we collect. On balance, we believe that this method will provide useful information to help clarify and complement information from other sources.

We suggest that each focus group be comprised of beneficiaries in the same vulnerable group or groups. Participant selection would be based on beneficiary characteristics, characteristics of the health care system, and geographic region. We welcome commissioner insights about selection criteria.

Focus groups would be organized using baseline information about beneficiary characteristics. Specifically, baseline information would include beneficiary demographics like age, sex, race, education, and income level, health status factors such as the presence of selected chronic conditions and self-reported health status, several basic measures of access like health insurance coverage and availability of a usual source of care, and also whether the beneficiary is enrolled in a fee-for-service or a risk plan.

Assuming commissioner interest in this method, we would hire a contractor to facilitate focus group sessions. Because this idea is in its developmental stages, we would likely use pilot groups to evaluate utility of the method before making further decisions about the number of groups we would convene.

Participants will be asked questions to clarify the type of access problems they face as well as reasons for poor access. Focus group questions will explore beneficiary attitudes and beliefs that influence how they interact with the health care system, structure and other characteristics of the health care system that influence how beneficiaries access care, beneficiary use of different types of health care services, and beneficiary satisfaction with the care that they received.

I would like to open it up to comments or questions.

DR. MYERS: This is an extremely important and tricky area, and the first thing comment I would make is to go back to what Joe advised you to do earlier. That is to take a look at the emerging literature on patient-centered care and evaluation of care as opposed to the old patient satisfaction of care that dealt in many respects with the hotel functions with facilities. Whereas now the theory and the practice is to really deal with patients' concerns about the practice of medicine, the practices they're exposed to.

Susan Edgeman-Levitan, Paul Cleary, and Tom Delbanco's work at the Picker Institute in Boston are really serving now as the models. There are others as well and I think you can learn a lot from what the AHA and other groups have done with their work, and how they are applying it in their facilities.

I would think that you'd want to get a group that has experience with that approach, and has experience with creating focus groups using that approach before we actually invest the funds necessary to do this right. You can lose a lot of money very fast in this arena. Forming your questions, knowing the area very well before you walk in and what you're trying to get out of it is absolutely vital and I would encourage you to do a lot of homework up front and get that advice before you actually spend the dollars.

DR. WILENSKY: That's really good advice.

DR. KEMPER: One question I had is whether these focus groups might be double duty with some of the beneficiary choice work. That's just an idea to think about. And I don't know whether that just makes too much for one focus group or not.

I guess in terms of choosing the groups I would think it would be useful to choose the groups based on your literature review and any early analysis of where you've identified potential problems, and then make the whole focus to try to understand what the nature of what the barriers are to the problem.

I also think it's important not to necessarily go in assuming that there's an access problem. I think it would be more useful if you allow the group to tell you where access is good, where the system is working as well as where it's not. It might, in that context, be useful to have a couple of the groups -- I don't know how many you're going to do -- drawn from populations where you're not identifying an access problem, just to see whether you get a different kind of story from that group.

MS. NEWPORT: Our experience with focus groups, we've found that the best information and measures, informed measures that you can get out of it have to do with giving them something very concrete to react to. I think you've identified it very well in making sure you have the right moderators and that type of thing. So your challenge will be in this -- and I've always found them extremely interesting to observe -- is do give them something -- don't have a generalized discussion.

You're going to have to be very disciplined about what you're looking at and how you define those terms. I've seen focus groups with everything from a retired physicist to a retired housewife where the best reaction in there was the retired housewife. I think that you have to very clear, because -- they are the health care coordinators in this country basically. So I think that area I think we have to be -- and then it informs the rest of your study. It becomes that kind of amplification as opposed to sometimes hard line data. I think it's valuable; I really do.

DR. WILENSKY: These are obviously areas in which there are people both on the Commission and people in other areas where there's a great deal of expertise and I think it's only our concern -- it's a very good thing to do, but just make sure you inform yourself about what everybody else has learned.

Do you want to go to the early warning?

MS. PHILIP: In previous meetings the issue was raised on how MedPAC can obtain information on beneficiary access to care in a timely manner. A need for some type of early warning system was expressed. We need to answer questions like, where are the hot spots or areas where beneficiaries are experiencing access problems? And what are the characteristics of beneficiaries that are experiencing these problems?

To answer these questions we have developed a framework for a surveillance that we call the early warning system. The early warning system has two main pieces. First, the creation of a network of reporting organizations and government entities based on a selection criteria. Second, the development of a survey questionnaire that will effectively collect information about beneficiaries' access to care.

Reporting organizations can include nonprofit organizations, advocacy groups, research organizations. Government entities can include congressional offices, federal agencies.

In doing so, we will focus on vulnerable populations -- in conducting the early warning system we'll focus on vulnerable populations, including older beneficiaries, lower income beneficiaries, those with poor health status, and ethnic minorities.

The goals of the early warning system. We hope that the early warning system would allow us to identify emerging access problems. This could include problems of access in specific specialty groups, or access to specific types of services, or access problems within a geographic area.

By selecting organizations that represent or seek out input from vulnerable groups, we hope to identify characteristics of beneficiaries with access problems. Are the frail elderly in particular experiencing access problems? Are African-Americans in specific areas experiencing problems? And how about those without supplemental insurance, are they having problems accessing care?

Finally, from our observations or the responses we obtain from our questionnaire, we hope to generate hypotheses for further data analysis.

The early warning system method has several benefits, the primary is that we can obtain information in a timely manner. Soon after a beneficiary has reported an access problem to their congressperson or to a beneficiary advocacy organization, we can obtain that information depending on the periodicity of our survey. And I'll get to this later.

Also, this method of gathering information allows us to be systematic in our approach. Finally, the early warning system also allows us to be flexible in targeting specific geographic areas and in targeting specific beneficiary groups and services.

There are also definitely challenges of the early warning system. First, we lose the ability to have statistically testable observations since we have a limited number of responses and since the responses

will not be generalizable. Responses from organizations such as advocacy groups may also be biased and the responses could be subject to learning and gaming our survey.

In order to select organizations and government entities into the early warning system network we have created a selection criteria. Since the details of this are outlined in the mailing material, I'll just highlight a few points. The selection criteria includes the membership or constituent base of the organization or government entity. It also includes the mission or the mandate of the organization.

In the survey we could include questions to help determine whether the organizations fit our selection criteria. For example, what are the constituent membership characteristics of the organization? What percentage of members are elderly or disabled? And if we're surveying an organization that primarily represents providers, we could ask what percentage provides care to Medicare beneficiaries? How do these organizations obtain the information? Do they get this information through the Internet, through phone, public meetings?

The survey questions may also help to determine the reliability of responses. For example, the mission statement of a nonprofit organization, or the mandate of an agency, or the requirements of a subcontractor. These may be useful in determining whether the organization will actually obtain information on beneficiary access to care.

The survey questionnaire will, of course, then ask about beneficiaries access to care. Have beneficiaries reported problems of access? What are the demographic, health, and coverage characteristics of these beneficiaries? What are the reported barriers to access? Are they transportation, are they financial, et cetera?

If the Commission decides to go ahead with this approach, engage in beneficiaries access to care, there are certain methodical details that should be considered. Sample size. The size of the sample may vary depending on available resources and our immediate and long term needs for information.

In the short term, one option is to develop an early warning system network of nonprofit organizations and government entities based on the selection criteria that we have mentioned and then sample subset organizations and government entities for our survey. A rotating sample subset could help minimize the likelihood that respondents will learn responses and game our survey. Sample subsets could be based on region or timely issues, such as access to home health services.

In the longer term, we can choose from a few options. We can either maintain, expand, or narrow the existing network. Then we can continue to choose subsets to survey, or we can survey all the organizations within the network. If we go with a large scale sample, however, we may want to consider an external contract.

The survey administration method. We could either administer the questionnaire through mail, electronic mail, or telephone interview. The questionnaire could be administered on a quarterly basis, or on a needs basis. Other intervals are also worth considering.

And the use of supplemental questions to address timely issues. If an issue is drawing particular political attention, we can use supplemental questions to address that topic. The sample subset could also be selected to include organizations and government entities that focus on that specific topic.

Finally, once we do identify a hot spot or a specific area with access problems, we need to decide what to do. One option would be to more systematically research that problem. This could be done by surveying providers in that market, or we could also perform data analysis of that specific area by obtaining 100 percent of the claims data from HCFA of that particular area.

So there are several things to be considered and I'm sure you all have comments.

MS. NEWPORT: I guess my fundamental concern about this is that it's not going to be early or warning. I just don't think that you can possibly anticipate what's going to happen. I'll give you some examples. I have to always refer to the HMO industry because at least I have some understanding of what's going on there.

You can have something as simple as a provider group deciding not to renew their contract with a managed care entity, which happened just recently, just a few minutes ago. For a particular county, that may drive hundreds of beneficiaries to call their congressman and say, the sky is falling. The fact is these folks -- I'm not saying this is a positive outcome because it doesn't work for the HMOs either -- is that they have not lost access to care. They are just shifting back to fee-for-service if there's no other choice in that marketplace or that town or that county.

So I think it's very important, if you're going to have a hot spot response is being able -- and you've identified it. You have identified it, that there's this problem, there's anecdotal problems with some of this. The other part of it goes to, surveying and resurveying when there is a status quo, you're going to run out of people who are going to be willing to participate in those things. Even the most conscientious consumer group.

So having said all of this -- and I've got other concerns -- but there's a couple of areas where you can probably, maybe get reliable information. Some of them are the regional offices of HCFA. They are the folks that are online, at least on the managed care side, with their managed care contractors and can identify maybe some areas of potential upset. But again it's potential. It's sometimes in the eye of the beholder.

Even managed care doesn't know necessarily if a provider group is going insolvent until maybe they start hearing complaints from the physicians that are under contract that they're not being paid by

this other entity. Again, that may not translate into any access problems. That may just be a very geographically defined issue that may not be a problem.

I think the other reliable source is consumer groups. They are the ones that are getting the calls. But again, you have to view that in context. You could have -- and I'm picking a number just to be arbitrary -- a 5 percent complaint rate for X number of beneficiaries in that area, and that could be absolutely normal for decades at a time, or not. But I think it gets really difficult to sort of pick out what's really a hot spot. It could disappear in a week. And I think that's the problem with trying to deal with this.

But I would really get to, try to define a fairly reliable resource for your information, and sort of stick to that and maybe have some sort of informal networking or something. But I don't know that a standard survey going out quarterly is going to give you anything because a week later after you get the results of that survey tabulated, something which you had absolutely -- no one could ever define -- would come up.

I think right now -- maybe this will settle out in a couple years. I hope so. But right now I don't think you're going to have anything that is putting you anything but behind the curve on a lot of this. Because even some managed care entities are behind the curve on some of it. They don't know they have a problem because it hasn't exploded yet, because a provider system is going insolvent.

DR. LAVE: I guess the concern that I have is that it seems to me that this is a very complicated thing to do, and that we have to put a lot more time and thought into how to do it if we're going to do it. The other concern that I have is that we've got an awful lot of stuff on our plate in the access issue. I mean, we're talking about sort of mounting focus groups, we're talking about analyzing data that hasn't been analyzed before. I'm concerned about sort of being spread relatively thin on some of these issues.

I guess that it might be better to do some detective work on how you might want to do an early warning line rather than do anything in place, but to sort of have that on the back burner. Talk to some

area-wide agencies on aging. You know, I keep thinking about if I -- of all the old people I know, who would they call? It's not even clear to me who some of them would know in fact who to call, who their groups were. The AARP clearly is...

So I would put that sort of in a detective, on the back burner, because I'm concerned about the amount of effort we've put on here and the amount of data analysis and stretching ourselves too thin I think.

DR. WILENSKY: We had gotten into this idea of early warning because we were concerned by the time we could actually see it for a fact it would be way after the fact when something had occurred. But the issue, because it is so difficult to pick it up without having a way to systematically assess responses to questionnaires or to other factors is -- I mean, the flip side of that, it's very hard to know you've got something.

So we may want to try to remind ourselves, this is what we were concerned about. But the right way to do it -- I mean, I don't want to challenge this issue. We need to spend more time both thinking about how to try to do an early warning system and where to put it in the priority with regard to some of these other issues that were raised.

MR. MacBAIN: Judy used the phrase, distant early warning which brought back memories of the dew line of radar installations across the northern part of Canada back in the days of bombers, which didn't do you much good if you were in northern Canada, but it was helpful if you lived somewhat further south. I think similarly on Janet's point, for those of us who live on the West Coast, we've come to view California as our dew line. And if you can measure what's happening in California, it will at least give the rest of us a sense of what's coming.

MR. SHEA: You could add Florida.

MR. MacBAIN: A little less facetiously, in picking agencies to be our data sources in this, have you had any opportunity yet to gauge how well they can accumulate and store the data to complete a quarterly questionnaire? For instance, do congressional offices maintain these kinds of complaints in a systematic way so they could report by categories, or are they even willing, or do their have the staff to do that sort of systematic reporting?

And I think Judy's point too of who do people call is a good one. Maybe we need to do a little broader look.

Also there's another source of information that we may want to tap, and that's the trade associations. If we're concerned that urologists are going to start dropping out of Medicare because the rates are no good, Ted is likely to hear about that before anybody actually does something. That is an early warning system. Similarly, if nursing homes start looking askance at certain types of Medicare admissions, their trade associations are going to --

DR. ROSS: There's an issue of false positives there.

DR. WILENSKY: Yes, we've had somewhat -- I'm not sure we would --

MR. MacBAIN: That's the issue of manipulating that this area has.

DR. WILENSKY: I'm not sure we would find that to have been a very accurate predictor. But it could at least say, we want to go look at participation rates. Here's a way to go look.

MR. MacBAIN: The radars in Canada occasionally picked up flights of geese.

DR. LEWERS: I agree with Janet and Bill in particular. We started this, as I recall, because we weren't comfortable with the data we were getting and it was late. Because when you get it in the surveys, that's usually -- it's over and done with by that point in time. At that point we began this, we talked about some

of the early warnings of being with physicians and physicians' offices and the services that they're providing. And as Janet says, payment delays are an early sign that you're going to begin to see perhaps someone fail.

But I noted in the paper you said you wanted to sort of stay away from physicians and other providers. But knowing whether physicians are laying off some of their office staff, which is occurring in certain areas. They lay off -- they had two nurses; they're down to one nurse. So the services that are being provided in the office have diminished. These are early warning signs that we were trying to get to at that point, and I don't think that we've addressed them. I don't think they're easy to get to, but they're the earliest signs I think you can get that you've got problems coming into an area.

In Maryland we've just had another physician network group go belly up. The warning signs were there a long time ago about changes in personnel, going out and raising more money, another group coming in and investing in them, and another group of investors getting out. All of these are clues that -- you know, we knew a year ago this group was going to go down. While they kept denying, and everything is fine, the warning signs are laid out there.

I think that's some of the material, that if you're going to do it -- and I agree with Janet, it's nice to have it. But you're going to have to look at that sort of information, which as far as I'm concerned, the beneficiaries aren't going to see. They're going to be the last one to basically come up and say, that's the problem, or going to be a problem.

So I don't know how you design that, but there are signs out there, particularly right now with groups that are failing and groups that are in financial trouble, that if we could somehow work out a system to, if not survey it, but at least track it. I don't know quite how to do that from a point of view, but that would be my recommendation or consideration.

DR. WILENSKY: I just want to remind people that one of the things that we have done is that we are doing some of our own surveys in order to try to get information. So that this may respond to some of what we were looking for before.

MR. SHEA: I think this should teach the staff for responding to a commissioner's request. I actually think what you have here is not a first cut, but sort of a rough list of all the things that might happen, and I agree with my colleagues about needing to sort this out. You may find that there would be even some national resources like through AARP. But mostly you're going to -- this is a matter of constructing something locally.

So I think what that suggests to me anyhow is to think about a couple of experiments, a couple pilots in significant size areas or states where you could test different methods on that. Ted's ideas about some of the more detective work; you know, what are the signs that indicate trouble is coming down the road.

I also think that even if we were hearing about things just as they, or relatively soon after they impacted the beneficiary level, like groups cutting back services and so forth, that's still a lot earlier than anything we're getting now, and would be worthwhile. But what exactly would be worthwhile investing a fair amount of time and resources over time I think you can only figure out by testing out a few things, which means it's going to take a while to develop this.

But I think this is actually very worth doing, given the amount of change that -- I mean, I think our original idea was right, and I think a lot of what you've come up here with, Susan, and your colleagues, is a good list to work from. I have some specific suggestions, but maybe we could just follow up and I could send them to you.

DR. WILENSKY: I have Peter and then Bill Curreri and Janet. Can I ask people to try to keep these comments short so we can get to our last session?

DR. KEMPER: First, short comment. I don't think any systematic data collection is going to be able to get at geographic, small area geographic problems. So I just don't think we're going to be able to get at that through any early warning system, and trying to do it might just make the whole effort less useful.

Secondly, I thought you did a nice job of laying this out, but having it -- seeing what we asked for laid out in this way made me wonder whether we were going to get from it what we thought we were going to get from it. I certainly would agree with Gerry, I would not go forward without some very careful pre-testing and letting us look at it to see if it's really going to yield anything that is our response to the early warning desire that we so clearly expressed.

I guess the third thought I had was, I wonder whether, following up on what Ted said, physicians might be a good source of information on problems with some -- not so much what's happening to the practices, but simply asking them as part of the physician survey some very focused questions like, during the last two weeks have you had any Medicare patient who had trouble getting services that were needed, or some very targeted questions to elicit problems just as flags. I don't know if that would be of value or not. Something to think about as piggybacking on the other work.

DR. CURRERI: I think I disagree with many of the other commissioners. I happen to think, number one, this is very important and should be of high priority. You'll recall that the reason that we thought that this was something of high priority was when we were questioning the representative from HCFA who was telling us about the preliminary publication of the practice portion of the fee schedule.

Joe and I, I think, both asked him how would they know if the change in fees resulted in an access problem and he said, we have that data. But it turned out in early 1998 we were looking at 1995 data,

and that there's at least a two-year lag before we would know whether any of these changes are causing a problem. And I think that's unacceptable.

DR. WILENSKY: But Bill, part of what we're proposing is to do some of our own survey work about access.

DR. CURRERI: I understand that. But I'm just saying that, a lot of people are saying that early warning isn't important and I think it is.

DR. KEMPER: Nobody said that.

DR. CURRERI: Let me just say that, we had some experience with this on the PPRC and one thing we found that the legislative bodies here on the Capitol, that is the staff of the Congress and the Senate, were not very good sources of complaints. I guess Medicare people with problems don't think to call their senators or congressmen, or at least that was our experience at that time.

AARP was a very cooperative group, but they tended to draw in people that were complainers because they would put a little notice in their paper and say, if you have an access problem, write to us. And that got us a lot of people that had an access problem when there wasn't any.

I think though, I was just looking at this book that Murray sent us. I don't know if you all read it, but it's really a very nice publication. In the back of this book, every state has an agency on aging, or a commission on aging, in which it says, if you have problems with your health care system call this number and it gives a free number. Now I don't know whether people read this book, but it seems to me you at least have one statewide source, if they are responding to this 1998 guide, where you might be able to at least in a pilot have 50 or so people that you could contact on a regular basis.

Do you have any experience with these commissions on aging and whether that's a good source?

MS. NEWPORT: Yes, that's a good source.

DR. CURRERI: So that would simplify things, rather than to do all these different things at once, just to see if you can pick up some problems at a statewide level at least.

DR. WILENSKY: My sense again is that I don't think there's any less interest. I think there's an issue between the survey on access work that you're going to do, the surveys you're going to do anyway, and to try to pilot some ideas to see whether there's a way to not have to wait two or three years after the fact. But be cautious and careful and come back to us before you get too far down the line.

Thank you.

Can we have the last session on access to home health services? Louisa?

MS. BUATTI: As you know, the fiscal year 1999 budget contains several provisions affecting home health care. Among these are additional reporting requirements for MedPAC and the Administration. I'd like to go over those now.

First, the Secretary is required to describe her research activities for the development of a prospective payment system and outline her plans for implementing such a system. This report is due to the Congress by

January 1st, 1999. MedPAC is required to comment on this report no later than 60 days after it is submitted to the Congress. That means that if it's on schedule that we will be submitting a comment later right around the time of our March report.

The Commission is also required to analyze access to home health services under the IPS and include its findings in the June 1999 report. I'll just quickly go over our workplans to examine access to care.

Right now we're planning to use a four-pronged approach to identify potential access problems. This would involve looking at the supply of home health providers, utilization of home health services, and to a lesser extent we'll attempt to learn about beneficiary perceptions about access to care.

The projects we have planned, first, an examination of home health agencies survey and certification data, a survey of home health providers, an analysis of Medicare home health claims data, and panel discussions with individuals responsible for arranging for home health services.

We're planning to look at the survey and certification data to give us a better sense of the availability of home health services. We'll use this information to identify the numbers of home health agency openings and closures since the implementation of IPS. And we'll use this information to target our other analyses toward areas where the number of providers has decreased, possibly indicating areas where there are access problems. We're planning to start work in this area in late December and early January.

Our second project will help us learn more about how the payment levels imposed by the BBA as well as

the 1999 budget provisions have affected home health agencies' ability to provide care for Medicare beneficiaries. We have heard anecdotal reports that some agencies are struggling to understand how the IPS limits work, and that some agencies are closing based on misinformation about how the limits are set.

So to get a better understanding of that, we plan to conduct a survey of home health providers to gauge their understanding of the IPS system, and also to determine if the payment limit changes have influenced provider behavior.

On that second point, we would try to learn more about whether agencies are still surveying the same numbers and types of Medicare beneficiaries and whether their practice patterns have changed as a result of the new payment limits. This survey would be conducted in February and March.

The third project we're considering is an analysis of home health claims data. We intend to examine Medicare home health claims from October 1997 through March 1998. This represents the first six months during which time the interim payment system was in effect. We would look at later claims data if they become available, but right now we're pretty certain that this is the latest we could get.

In that analysis we would compare utilization rates with the previous year. We'd also look at whether or not agencies that were bound by the IPS limits at that time with those for agencies that had not yet begun the interim payment system.

In addition, we would compare the numbers and types of agencies submitting home health claims during this period with the survey and certification data, just to get a better sense of, in fact, the supply of providers. Finally, we'll use this information to compare with the responses from the provider survey about utilization.

In the claims analysis we'll look at both the number of beneficiaries receiving home health services as well as the number and mix of services that they're receiving. This should help us identify areas where problems will exist. This claims data analysis will start as soon as the data are available and we expect to have it in the next month or so.

Then finally, our last project is an attempt to gain a deeper understanding of beneficiaries' perceptions about access to home health services. We intend to convene panel discussions with beneficiary advocates and individuals experienced in arranging for home health services. We would contact area agencies on aging and hospital discharge planners to find out if they're experiencing difficulty in placing beneficiaries into home care. We also hope to learn from them whether beneficiaries are expressing dissatisfaction with the level of care they're receiving or the types of services they're receiving.

The panelists will be selected from a range of geographic areas representing differences in historical utilization patterns, payment limits, and agency supplies. We'll also use the results of the provider survey to select our candidates for the panels. We recognize that this is an indirect way of getting information about beneficiary perceptions, but given the limited time frame we have, we think this is a reasonable one.

So I'd be happy to hear your comments.

DR. NEWHOUSE: A couple of questions. On the survey of the providers, are you going to do anything to validate responses?

MS. BUATTI: We would look at the claims.

DR. NEWHOUSE: At the claims. Using the results or sampling in areas with closures, I assume you're going to just oversample there because -- that you'll have some other group for comparison.

MS. BUATTI: Yes, right.

DR. KEMPER: One thought occurs to me that in a sense this is an early warning system or maybe the early warning system was through the industry reaction and the trade associations and Congress. But this has some real appeal in the sense that it's targeted at a particular change where we expect that there might be problems that arise and goes after that.

I think one thing that I would even urge you to target more is areas where -- along dimensions where the payment changes lead you to expect that there might be a change. So more targeting I think might be useful.

MS. BUATTI: Right.

DR. KEMPER: Secondly, I may have misread the materials but it seemed to me at some points you might have been focusing on just part of the picture, the closures of agencies, or at another point, just the utilization on continuing agencies.

It seems to me it's important to look at the total set of agencies and look t the net change of closures and openings or whatever the term is, or utilization including ones that have closed and ones that have started up, so that you get the full picture of the net changes.

MS. BUATTI: Okay.

DR. KEMPER: The other comment that I would have is that these issues aren't going to go away. So in figuring out what the short term plan is we might want to think about putting in place some things that could be repeated in a year or two because there are going to be other payment changes that are going to raise some more kinds of issues. So not just focus on the short run but identify things for the longer run as well.

MS. BUATTI: Okay.

DR. WILENSKY: Any further comments?

Thank you. I think we've worn the commissioners out. Thank you, this was a very productive two days.

Are there any audience comments?

DR. NEWHOUSE: We've worn the audience out.

DR. WILENSKY: We have. We will be meeting in December. The information will be on the web site, and we'll get the information to commissioners as soon as we can.

Happy Thanksgiving, everyone.

[Whereupon, at 3:00 p.m., the meeting was adjourned.]